UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

PATRICIA SINTICH, on behalf of herself and all others similarly situated,	)	
Plaintiff,	)	Case No. _____
v.	)	**FILED: JULY 31, 2008**
HEALTH CARE SERVICE CORPORATION and PEOPLES ENERGY CORPORATION MEDICAL AND DENTAL PLAN,	)	**08CV4360** **JUDGE HART** **MAGISTRATE JUDGE BROWN**
Defendants.	)	**AEE**

CLASS ACTION COMPLAINT

Plaintiff Patricia Sintich, on behalf of herself and all others similarly situated, makes this her Class Action Complaint, and alleges the following upon information and belief:

INTRODUCTION

This action challenges the misuse by Health Care Service Corporation ("Blue Cross") of its position as the fiduciary claims administrator for class members' health plans to cause them to pay more than the coinsurance provided for under the terms of their plans and—acting on a direct conflict of interest—to retain the difference ***and*** conceal its practice from participants. The health plans at issue provide that benefits for in-network services are payable at a percentage of what is called the Schedule of Maximum Allowances (or "SMA"), which under the plan documents consists of the amounts in-network providers have agreed to accept as payment for their services. Participants are then responsible for paying the remaining percentage as coinsurance. Blue Cross does ***not*** process claims in this manner.

Specifically, Blue Cross secretly negotiates discounts with health care providers, but informs participants that it has approved higher charges as benefits and instructs participants to

pay coinsurance based on the higher charges. Blue Cross then pays the provider only the difference between the secretly negotiated charge and the participants' coinsurance obligation, and thereby keeps the extra coinsurance payment ***for itself***. As set forth below, Blue Cross's misconduct violates a number of ERISA's statutory provisions.

NATURE OF ACTION

1. Plaintiff brings this action under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, on behalf of participants and beneficiaries in ERISA-covered health plans that are insured and/or administered by Blue Cross, including without limitation the Peoples Energy Corporation Medical and Dental Plan (the "Plan").

2. Through this lawsuit, Plaintiff seeks to have the plans administered in accordance with their terms, to recover benefits due to participants, to clarify participants' rights to future benefits, and to obtain further relief to remedy Blue Cross's prohibited transactions and breaches of fiduciary duties under ERISA.

JURISDICTION AND VENUE

3. This action is brought pursuant to the civil enforcement provisions of ERISA § 502(a), 29 U.S.C. § 1132(a).

4. This Court has subject matter jurisdiction over this action pursuant to ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1).

5. This Court has personal jurisdiction over Blue Cross as it is a citizen of the State of Illinois.

6. Venue is proper in this judicial District pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2), because Blue Cross resides and may be found within this District, many of the

health plans at issue are administered in this District, and many of Blue Cross's fiduciary breaches took place in this District.

PARTIES

7. Plaintiff Patricia Sintich is a resident of Illinois and a beneficiary of the Plan. The Plan is an ERISA-covered health plan sponsored by her husband's employer, Integrys Energy Group, Inc. ("Integrys"). Integrys was formed when Peoples Energy Corporation and WPS Resources Corporation merged in February 2007.

8. Defendant Health Care Service Corporation ("Blue Cross") is a Mutual Legal Reserve Company headquartered in Chicago, Illinois. Blue Cross underwrites and administers health and dental insurance plans throughout Illinois, New Mexico, Oklahoma and Texas. It is an independent licensee of the Blue Cross and Blue Shield Association and conducts business in those states under the names BlueCross BlueShield of Illinois, BlueCross Blue Shield of New Mexico, BlueCross Blue Shield of Oklahoma and BlueCross BlueShield of Texas, respectively. Blue Cross is the fiduciary claims administrator for medical claims under the Plan and other ERISA-covered health and dental plans, and its business encompasses processing health and dental claims on a large scale, in a mostly automated manner.

9. Defendant Peoples Energy Corporation Medical and Dental Plan (the "Plan") is an "employee welfare benefit plan" within the meaning of ERISA § 3(1), 29 U.S.C. § 1002(1), which is maintained by Integrys for the purpose of providing medical and dental coverage to eligible employees, retirees and their dependents such as Plaintiff.

FACTUAL ALLEGATIONS

10. In an ERISA action such as this, challenging the claims practices of a plan fiduciary, the information and documents on which a plaintiff's claims are based are, for the

most part, exclusively within the defendants' possession and control. This is particularly true here where, as set forth more fully below, Plaintiff received no response to her formal appeal of the determinations of her benefits. Plaintiff may therefore find it appropriate to amend her complaint in light of discovery. Except for matters regarding Plaintiff, her family and Plan documents, the facts are pled on information and belief.

The Plan Documents

11. ERISA requires that every employee benefit plan be established and maintained pursuant to a written plan instrument. ERISA § 402, 29 U.S.C. § 1102. The Plan here was established and maintained pursuant to a written Plan document entitled "Peoples Energy Corporation Medical and Dental Plan (Effective January 1, 2002)," a copy of which is attached as Exhibit 1.

12. ERISA also requires that a summary plan description ("SPD") be furnished to participants and beneficiaries for all ERISA-covered employee benefit plans. An SPD must contain specific information regarding the plan and "be written in a manner calculated to be understood by the average plan participant, and … be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." ERISA § 102, 29 U.S.C. § 1022.

13. The SPD for the Plan was included as a part of a Benefits Handbook distributed to participants. Plaintiff is in possession of two versions of the SPD: an undated version and a later version that bears the designation "Printed 08/2007." Excerpts from these SPDs are attached as Exhibits 2-3 (the undated SPD) and Exhibits 4-5 (the 2007 SPD).

14. The 2007 SPD also refers participants to the "Health Care Benefits Comparison Chart for a general comparison of benefits of each option under the Medical and Dental Plan,"

and states that such charts are "issued annually at the open enrollment time and should be kept at the back of this section of your handbook." Ex. 4 at 4. A copy of the 2007 benefit comparison chart for nonunion employees is attached as Exhibit 6.

Funding Of The Plan

15. The cost of the Plan is shared between participants and Integrys. A participant makes two different monthly contributions, one for the medical portion of the Plan and one for the dental portion of the Plan. Ex. 4 at 7. The monthly contribution rates for employees and retirees are based upon Integrys's total monthly cost to provide medical benefits to the covered individuals in each group. Ex. 1 at 6.

16. Integrys collects participant contributions by means of payroll deductions. It then deposits the participant contributions as well as its own contributions in trusts to provide for the payment of benefits. Ex. 4 at 7.

Blue Cross's Role With Regard To The Plan

17. The SPDs identify Blue Cross as the Claims Administrator for medical claims under the PPO option of the Plan. Ex. 3 at 6; Ex. 5 at 7.

18. The term "Claims Administrator" is defined by the Plan document to mean "the organization(s) retained by the Company to provide administrative services for payment of benefits under this Plan as well as related support services." Ex. 1 at 34. The Plan document also provides, "Certain administrative duties are delegated to the Claims Administrator under various provisions of the Plan. The Committee may also delegate other specific duties to the Claims Administrator…." Ex. 1 at 58.

19. The reference to the Committee in the preceding plan language is to the Retirement and Benefit Plans Committee, which serves as the plan administrator and named

fiduciary of the Plan. Ex. 1 at 58. Plaintiff believes and therefore avers that the Committee delegated substantial discretionary authority to Blue Cross.

20. In its role as Claims Administrator, Blue Cross exercises discretionary authority and discretionary control respecting management of the Plan, it exercises authority and control respecting management and disposition of the Plan's assets, and it has extensive discretionary authority and discretionary responsibility in the administration of the Plan. Accordingly, Blue Cross is a fiduciary of the Plan within the meaning of ERISA § 3(21), 29 U.S.C. § 1002(21). Blue Cross is responsible for, *inter alia*, reviewing and determining whether to pay or deny claims, determining the amount of benefits to be paid and participants' coinsurance obligations, communicating its benefit determinations to participants through explanations of benefits ("EOBs"), answering questions from participants regarding its benefits determinations, reviewing any additional information provided by participants, and reevaluating its benefit determinations as appropriate in light of such additional information. Ex. 1 at 48.

21. In addition, two exclusions of coverage are within Blue Cross's discretionary control. Charges in excess of the Schedule of Maximum Allowances are excluded from coverage, Ex. 1 at 25, and as the Claims Administrator, Blue Cross alone is responsible for establishing, maintaining, and applying the Schedule of Maximum Allowances based on the amounts it has negotiated with in-network providers as payment in full for their services. See, e.g., Ex. 1 at 9, 10, 12, 38; Ex. 2 at 2, 6, 9, 23; Ex. 4 at 19, 21, 23; Ex. 6 at 1. In addition, the Plan document broadly provides that charges not considered appropriate under Blue Cross's administrative practices are excluded from coverage. Ex. 1 at 25.

Benefits For In-Network Services Under The Plan Documents

22. Under the Plan document, benefits for many in-network services are payable at a percentage of the "Schedule of Maximum Allowances," which the Plan document defines as "those charges for medical services as negotiated by the Preferred Provider Organization for In-Network Services." Ex. 1 at 38. For example, expenses related to inpatient care at a recognized hospital are "Payable at 90% (for Union Employees and Retirees) and 80% (for Nonunion Employees and Retirees) of the Claims Administrator's Schedule of Maximum Allowances following satisfaction of a deductible for in-network charges…." Ex. 1 at 9.

23. The Plan document contains essentially identical language with respect to benefits for outpatient care, home health care, extended care facilities, inpatient hospice care and hospice home care services. Ex. 1 at 12, 14-17.

24. The SPDs state:

> [The Plan] generally pays 90 percent (union) or 80 percent (nonunion) of in-network charges (subject to the Schedule of Maximum Allowances determined by the Claims Administrator) …. The Schedule of Maximum Allowances represents discounted amounts for services negotiated by BlueCross BlueShield with contracted providers.

Ex. 2 at 6; Ex. 4 at 21.

25. The SPDs further explain that "All in-network medical expenses, except those for mental health/substance abuse and prescription drugs, are subject to the Schedule of Maximum Allowances determined by the Claims Administrator based on what the participating professional providers have agreed to accept as payment in full for a particular covered service." Ex. 2 at 2; Ex. 4 at 19.

26. The benefits comparison chart lists thirty types of services for which benefits are payable as a percentage of the SMA. It further states, "The SMA is the amount determined by

BlueCross BlueShield, which Participating Professional Providers have agreed to accept as payment in full for a particular covered service." Ex. 6.

27. The Plan also provides for a lifetime benefit maximum that is based in part on the benefits paid under the SMA benefits provisions set forth above. Ex. 1 at 23.

Blue Cross's Mishandling of Plaintiff's Medical Claims

28. On February 9, 2007, Ms. Sintich received covered medical services consisting of surgery and related services (operating room, recovery room, drugs and supplies) from Justice Medical Surgical Center ("Justice"), an in-network provider. Under the Plan, benefits for such services are payable at 80% of the SMA for beneficiaries of nonunion employees such as Ms. Sintich.

29. An excerpt from the EOB that Blue Cross sent to Ms. Sintich in connection with these services is attached as Exhibit 7. The EOB shows covered charges of $7,229.16, but states, "Blue Cross and Blue Shield has negotiated discounts with this provider. The following shows how the BCBS discount (ADP) is used to help lower your out-of-pocket expenses." The discount reflected on the EOB is $4,662.80. The after-discount balance of $2,566.36 was allocated 80% to Blue Cross ($2053.10) and 20% to Ms. Sintich ($513.26). Ms. Sintich paid the $513.26 as directed.

30. Justice's statement to Ms. Sintich in connection with these services tells a different story. It is attached as Exhibit 8. Like the EOB, the statement reflects that Justice's billed charges for the services were $7,229.16. However, the statement reflects a discount or "contract adjustment" in the amount of $5,729.16—over $1,000 more than the discount shown on the EOB that was sent to Plaintiff. Justice informed Ms. Sintich that this "contract

adjustment" reflects its contractual agreement with Blue Cross to accept $1,500.00 per case as payment in full for the services it provided to her.

31. In a letter to the Illinois Office of Attorney General dated October 5, 2007, Justice stated that while Blue Cross initially paid $6,715.90 to it on Ms. Sintich's claim, Justice later refunded $5,829.16 back to Blue Cross, and thus the payment Justice ultimately received from Blue Cross "after reconciliation" was $986.74. A copy of Justice's letter to Office of Attorney General and its attached documentation is included as part of Exhibit 9.

32. In accordance with the Plan terms, Blue Cross should have paid 80% of the $1,500.00 that Justice agreed to accept as payment in full for the covered services under the provider's contract with Blue Cross, or $1,200.00. Ms. Sintich's coinsurance responsibility in connection with the charges should have been 20% of $1,500.00, or $300.00. Contrary to the Plan terms, however, Blue Cross determined that Ms. Sintich's coinsurance responsibility for the claim was $513.26 (34%) and paid only $986.74 (66%) to Justice. See Ex. 7 and Ex. 8. ***Through this scheme, Blue Cross not only overcharged Ms. Sintich in connection with the claim, Blue Cross retained the extra $213.26 paid by Ms. Sintich in coinsurance***.

33. In summary, Ms. Sintich paid $513.26 and the Plan paid $2053.10 in connection the Justice claim, for a total of $2566.36. Of that total, Justice received $1500 for the surgery and related services it provided, while Blue Cross received $1,066.36—about 41% of the total paid and more than two-thirds of what the surgical facility itself received—for processing a single claim using a computerized and mostly automated claims processing system.

34. On January 30, 2007, Ms. Sintich received services from Northwestern Memorial Hospital ("Northwestern"). An excerpt from Blue Cross's EOB for the claim submitted for these services is attached as Exhibit 10. The EOB reflects billed charges of $3,691.72, and a discount

of $1,801.55, leaving an after-discount balance of $1,890.17. The EOB further reflects that Blue Cross approved benefits of 80% of this balance ($1,512.14), and determined that Ms. Sintich's coinsurance obligation was 20% of this balance ($378.03).

35. When Ms. Sintich contacted Northwestern, however, its representatives informed her that the payment Northwestern actually received from Blue Cross was less than $1,512.14. The representatives declined to tell Ms. Sintich exactly what the hospital's actual contract rate with Blue Cross was, but verified that the amounts listed in the EOB do not reflect the actual payment Northwestern received from Blue Cross, nor the true discount amount. Thus, contrary to the Plan terms, the coinsurance amount Blue Cross calculated for Ms. Sintich was greater than 20% of the amount Northwestern agreed to accept as payment.

36. As with the Justice claim, Blue Cross overcharged Ms. Sintich in connection with the Northwestern claim and retained the extra coinsurance paid by Ms. Sintich.

The Inconsistent And Inadequate Responses To Plaintiff's Inquiries

37. Ms. Sintich made informal inquiries to both Blue Cross and Integrys regarding the above claims because she believed there was a disparity between the amounts her providers accepted as payment and the amounts on which Blue Cross based her coinsurance. She contacted Integrys on April 24, 2007.

38. Integrys responded by letter dated June 7, 2007, authored by Ms. Joyce Daniel, who held the position of Manager, Benefits Administration at Integrys. A copy is attached as Exhibit 11. The letter states, in pertinent part:

> You questioned the amount of your $513.26 co-insurance for a procedure done on February 9th at the Justice Medical Surgical Center. As stated in the Peoples Energy Benefits Handbook, all in-network medical expenses are subject to the Schedule of Maximum Allowances (SMA). The SMA is the amount determined by BCBS which Participating Professional

> Providers have agreed to accept as payment in full for a particular covered service. All benefits payments for services rendered by Participating Professional Providers will be based on the SMA.
>
> The SMA for this procedure was $2,566.36 making your twenty percent co-insurance $513.26. The contract between BCBS and its in-network facilities states that the full amount is paid upfront, (in this case $6,715.90). Then the Participating Professional Providers will reimburse BCBS through a reconciliation process for the discount amount. However, the Plan is only invoiced and pays for eighty percent of the SMA or ($2,053.10).
>
> The same explanation holds true for the benefits approved and paid to Northwestern Memorial Hospital for your March Services.
>
> You also expressed some concern about the reduced amount BCBS paid to the Justice Medical Surgical Center and Northwestern Memorial Hospital. BCBS has a separate financial arrangement with Participating Professional Providers that allows BCBS to pay less, often substantially less, and requires the hospital or facility to accept less than the amount of money BCBS would be required to pay if it did not have a contract. BCBS receives and keeps for its own account the difference between the bill and whatever BCBS ultimately pays under its contracts with Participating Professional Providers and neither you nor the Plan is entitled to any part of these savings.

39. Ms. Sintich wrote to Integrys in a letter dated July 19, 2007, providing additional information and documentation regarding the Justice and Northwestern claims, and questioning the payment practices described in Ms. Daniels's letter in light of the language of the SPD. A copy is attached as Exhibit 12. Since Ms. Daniels had advised she was retiring, Ms. Sintich requested that the letter be forwarded to her successor.

40. It was not until November 19, 2007 that Integrys responded to Ms. Sintich's letter. A copy of the response, a letter authored by Jennifer Niemi, Benefits Manager, is attached as Exhibit 13. Ms. Niemi gave an entirely different justification for the handling of Ms. Sintich's claims. Her letter states in part:

> Please be advised that the Schedule of Maximum Allowances (SMA) as stated in your Benefits Summary applies to **Professional** Providers. In fact as you quote the Benefits Summary in your letter it reads:
>
> ***The amount determined by Blue Cross Blue Shield which Participating Professional Providers have agreed to accept as payment in full for a particular covered service.***
>
> It should be noted that Justice Medical Surgical Center is a licensed Ambulatory Surgical Center and has a facility contract with BCBS. As a surgery center, they bill for operating room, supplies and other items that are included in a case rate negotiated by BCBS for the service. Licensed surgery centers, like hospitals, are not reimbursed by the SMA but are reimbursed at the individually negotiated rate stated in their contract with BCBS.
>
> BCBS has separate, individual financial arrangements with facilities. Customers and members are entitled to the Average Discount Percentage (ADP) of these contracts; the average determined by the grouping by facility type and geography. …

Ex. 13 at 1 (all emphasis in original).

41. Ms. Niemi's letter concluded that it was Integrys's "determination that the claims have been paid in accordance with plan provisions and no additional benefits are due." Ex. 13 at 2. The letter also enclosed an excerpt from an unidentified document, which was described as "specific BCBSIL contract language that explains the separate financial arrangements with providers…." Ex. 13 at 1. A copy of this fragmentary document, which had never before been provided to Ms. Sintich, and which Blue Cross later declined to provide the remainder of, is attached as Exhibit 14.

42. On January 24, 2008, Ms. Sintich wrote to both Integrys and Blue Cross to formally appeal Blue Cross's determination of her claims. A copy of this letter is attached as Exhibit 15. Ms. Sintich's appeal letter stated, among other things:

> I have already been in contact with BCBS and the Human Resources Department regarding these claims on an informal basis, without any success or satisfactory explanation….

> I now want to formally pursue the matter. This letter is intended to be a formal claim for benefits for all claims where BCBS handled the claim as in the examples given above, i.e., where BCBS calculated the Plan member's co-insurance obligation to be 20% (or some other percentage) of the "Benefits Approved" as reflected in the EOBs, but paid amounts to the providers that were less than 80% of the "Benefits Approved" (or initially paid 80% of the "Benefits Approved" but then received rebates or payments from the providers in connection with the claim). This letter is also intended to cause the cessation of and seek an appropriate remedy for any misappropriations or misuses of my, others' or Plan funds to defray provider costs, as described above.

Ex. 15 at 3 (emphasis in original).

43. Ms. Sintich sent her appeal letter to both Blue Cross and Integrys because the SPDs and the Plan document are inconsistent on who should receive the appeal. The SPDs provide for three levels of appeal, with the first appeal to be handled by Blue Cross, the second to be handled by Integrys and the third to be handled by the Committee. Ex. 3 at 6; Ex. 5 at 6. The Plan document, however, provides that if a participant is not satisfied with the handling of a claim by Blue Cross, he or she may file a formal written claim for benefits with Integrys. Ex. 1 at 49. If that claim is then denied, the participant can appeal the claim to the Committee. Ex. 1 at 54.

44. Ms. Sintich's appeal letter advised Blue Cross and Integrys that, *inter alia*, Integrys's assertion that hospitals and licensed surgical centers are not reimbursed or using the SMA because they are not "professional" providers is contradicted by the language in the Plan document and the SPDs. Ex. 15 at 3. She specifically informed Blue Cross and Integrys that the Plan document "unequivocally states that benefits for in-network charges 'for outpatient Surgery performed at a doctor's office or clinic, Hospital or ambulatory surgical facility' are payable at 80% of the SMA…." Ex. 15 at 3 (quoting Ex. 1 at 12).

45. The SPDs are equally clear. They state, *inter alia*, "the amount charged in-network by a hospital or doctor will be determined based on the Schedule of Maximum Allowances." Ex. 2 at 10; Ex. 4 at 24.

46. Finally, Ms. Sintich's appeal letter requested specific information in connection with her appeal, including claims histories for herself and her family members, documents relied upon in making the benefits determinations, a complete copy of the fragmentary document attached to Ms. Niemi's November 19, 2007 letter, and other documents related to the Plan, the claims and Blue Cross's payment methodologies. Ex. 15 at 3-4.

47. On April 14, 2008, Ms. Sintich received the first communication in response to her January 24, 2008 correspondence—an email from Ms. Niemi on behalf of Integrys which stated, "We have been meeting with Blue Cross Blue Shield of Illinois and the respective legal counsel for both Integrys and BCBSIL to gather the data and our response. Our goal is to have our response to you by the end of [April]." A copy of this email is attached as Exhibit 16.

48. Nothing was received by the end of April. On May 20, 2008, Ms. Sintich received another email from Ms. Niemi on behalf of Integrys which stated, "As I indicated in my e-mail on 4/14/08, we've been working on our response to your letter of 1/24/08 with Blue Cross Blue Shield of Illinois and the respective legal counsel for both BCBSIL and Integrys. Unfortunately, our data gathering is taking longer than anticipated. We continue to work on your request and will have it to you as soon as possible." A copy of this email is attached as Exhibit 17.

49. As of the filing of this complaint, Ms. Sintich has not received any further or additional communications, or any response to her formal appeal of January 24, 2008. Ms.

Sintich is deemed to have exhausted the administrative remedies available to her under the Plan pursuant to 29 C.F.R. § 2560.503-1(l).

Blue Cross Secretly Overcharges Participants And Keeps The Difference For Itself

50. Based on the responses to her informal inquiries, Plaintiff believes and therefore avers that, contrary to the Plan document and the SPDs, Blue Cross did not pay claims for services of hospitals and other facilities—and possibly other providers—as a percentage of the Schedule of Maximum Allowances. As a result, additional benefits are owed to Plaintiff and the other participants and beneficiaries who are members of the class.

51. Notwithstanding the EOBs that Blue Cross issued to participants purporting to show that it was approving—and by implication paying—80% of the charges remaining after the discounts it had negotiated with the providers, Blue Cross's agreements with certain in-network providers apparently provide for additional discounts and payments to it from providers that were not provided for in the Plan document(s) or SPDs, or disclosed to participants.

52. Blue Cross keeps these additional discounts and payments from providers for its own account, the result of which is that participants do not receive their full benefits and are held financially responsible for more than the coinsurance obligations set forth in their plans.

53. Put another way, Blue Cross—acting on a clear conflict of interest—administers claims in a manner that causes participants to overpay with respect to coinsurance, and retains the difference for itself.

CLASS ACTION ALLEGATIONS

54. Plaintiff brings this action as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure. The requirements of Rule 23(a), 23(b)(1), 23(b)(2), and 23(b)(3) are satisfied with respect to the class defined herein.

55. The class consists of the following:

> All persons who, since July 31, 1998, have been participants or beneficiaries of the Plan or any other ERISA-covered employee welfare benefit plans for which Health Care Service Corporation ("Blue Cross") served as claims administrator, where (i) benefits are payable under the plan documents as a percentage of the Schedule of Maximum Allowances ("SMA"); (ii) the SMA is the amount providers have agreed to accept as payment for their services; (iii) the plan documents do not authorize any other discounts on payments to be made to the providers; and (iv) the participants' or beneficiaries' benefits, coinsurance and lifetime maxima were calculated on amounts that were more than the amount the providers agreed to accept as payment for their services.

56. Plaintiff estimates that there are thousands of class members. The exact number and identification of these persons can be determined from the records maintained or controlled by Blue Cross. The number of class members is so large that joinder of all its members is impracticable.

57. There are questions of law and fact common to the class, including at least the following:

a. whether Blue Cross has failed to pay the claims of class members for services received from certain providers as required by the plan documents;

b. whether, or to what extent, Blue Cross has informed class members that it has negotiated discounts from certain in-network providers that are not properly accounted for in computing class members' coinsurance obligations;

c. whether Blue Cross's claims practices result in class members' coinsurance obligations exceeding that which is authorized by the terms of their plans;

d. whether, or to what extent, Blue Cross has informed class members that it is not basing its benefits payments on the SMA;

e. whether Blue Cross has administered class members' claims in a manner consistent with the governing plan documents;

f. whether Blue Cross has violated its ERISA fiduciary duties through its conduct;

g. whether the consideration Blue Cross receives, and keeps for its own account, from providers in connection with benefits paid under the plans are prohibited transactions under ERISA;

h. whether Plaintiff and class members are owed additional benefits under the terms of their plans;

i. whether Plaintiff and class members are entitled to declaratory relief to clarify their rights to future benefits under their plans; and

j. whether Plaintiff and class members are entitled to obtain injunctive and other relief to remedy harms from the conduct alleged.

58. Plaintiff's claims are typical of the class. Her claims are brought under ERISA, which imposes a uniform standard of conduct on plan fiduciaries including a duty to uniformly administer and interpret common plan language.

59. Plaintiff will fairly and adequately protect the interests of the class. She has no interests antagonistic to the claims of the class. She has retained competent counsel experienced in class actions and ERISA litigation, who are advancing the costs of the litigation contingent on the outcome.

60. Because of the uniform standards of conduct imposed by ERISA, the prosecution of separate actions by individual members of the class would create a risk of: (i) inconsistent adjudications that would establish incompatible standards of conduct for Blue Cross, and (ii) adjudications that would be dispositive of the interests of non-party class members or substantially impair such non-party class members' ability to protect their interests.

61. Blue Cross has acted or refused to act on grounds generally applicable to the class as a whole, thereby making appropriate final injunctive relief, declaratory relief or other relief with respect to the class as a whole.

62. The common issues outlined above predominate over any issues affecting only individual members of the class and a class action is superior to any other method for the fair and efficient adjudication of this controversy.

63. Plaintiff is aware of no other litigation concerning this controversy already commenced by any member of the class.

64. There are no difficulties likely to be encountered in the management of a class action in light of the uniform standard of conduct ERISA imposes on plan fiduciaries and the common plan language at issue.

COUNT ONE

Claim for Benefits
(Brought Against Blue Cross)

65. Plaintiff incorporates by reference the allegations contained in the previous paragraphs of this complaint as if fully set forth herein.

66. ERISA provides that a participant or beneficiary may bring a civil action to recover benefits due to her. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

67. The plan documents for class members' plans provide for benefits for in-network services to be payable at a percentage of the SMA, which is the amount that Blue Cross has negotiated with in-network providers as payment in full for their services.

68. In connection with certain in-network claims, Blue Cross did not cause benefits to be paid at the percentage of the SMA set forth in class members' plan documents.

69. Acting on a clear conflict of interest, Blue Cross instead calculated class members' coinsurance obligation as a percentage of an amount greater than the SMA, and then paid the difference between the coinsurance obligation and the SMA as benefits—retaining the

difference for itself. In this manner, Blue Cross itself ended up with the very plan assets that should have been paid as benefits to class members.

70. Plaintiff and the class are entitled to recover the benefits due to them.

COUNT TWO

Claim for Relief to Enforce and Redress Violations of Plan Terms
(Brought Against Blue Cross)

71. Plaintiff incorporates by reference the allegations contained in the previous paragraphs of this complaint as if fully set forth herein.

72. ERISA provides that a participant or beneficiary may bring a civil action to enforce her rights under the terms of the plan, to clarify her rights to future benefits under the plan, to enjoin any act or practice which violates the terms of the plan, or to obtain other appropriate equitable relief to enforce any provisions of the plan. ERISA §§ 502(a)(1)(B) and 502(a)(3), 29 U.S.C. §§ 1132(a)(1)(B) and 1132(a)(3).

73. Through this count, Plaintiff and the class seek to: (i) enforce their right to have their benefits and coinsurance obligations calculated in accordance with their plan; (ii) clarify their rights to have future benefits and coinsurance obligations calculated as stated in their plans; (iii) enjoin Blue Cross from administering claims in a manner benefiting itself and contrary to plan provisions; and (iv) to obtain other appropriate equitable relief, including but not limited to the reprocessing of class members' claims in accordance with the plan terms and an accounting thereof.

COUNT THREE

Claim for Relief to Redress Prohibited Transactions
(Brought Against Blue Cross)

74. Plaintiff incorporates by reference the allegations contained in the previous paragraphs of this complaint as if fully set forth herein.

75. ERISA provides that a participant or beneficiary may bring a civil action to obtain appropriate equitable relief to redress violations of the statute. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3).

76. ERISA further provides that a fiduciary with respect to a plan shall not receive any consideration for its own personal account from any party dealing with such plan in connection with a transaction involving assets of the plan. ERISA § 406(b)(3), 29 U.S.C. § 1106(b)(3).

77. Blue Cross serves as a fiduciary with respect to class members' plans and the assets held to pay claims as set forth above.

78. Blue Cross receives consideration in the form of payments, discounts or other allowances from in-network providers in connection with transactions involving plan assets—i.e., claims for which benefits are paid out of plan assets. Blue Cross keeps such consideration "for its own account." Ex. 11, Ex. 13 and Ex. 14.

79. Blue Cross's receipt of consideration from providers in connection with class members' claims in this manner is a violation of ERISA § 406(b)(3), 29 U.S.C. § 1106(b)(3), and Plaintiff and the class are entitled to appropriate equitable relief to redress this violation, including but not limited to restitution, disgorgement and an accounting for profits.

COUNT FOUR

Claim for Relief to Redress Breaches of Fiduciary Duty
(Brought Against Blue Cross)

80. Plaintiff incorporates by reference the allegations contained in the previous paragraphs of this complaint as if fully set forth herein.

81. ERISA provides that a fiduciary has a duty of loyalty and to discharge its duties with respect to a plan solely in the interests of participants and beneficiaries, and for the

exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the plan. ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A).

82. The fiduciary duties of loyalty and exclusive purpose entail, *inter alia*, a duty to administer a plan with an "eye single" to the interests of participants and beneficiaries, regardless of the interests of the fiduciaries themselves or the plan sponsor, as well as a duty to disclose and inform, which duty encompasses: (i) a negative duty not to misinform; (ii) an affirmative duty to inform when a fiduciary knows or should know that silence might be harmful; and (iii) a duty to convey complete and accurate information material to the circumstances of the participants and beneficiaries.

83. ERISA further provides that a fiduciary shall discharge its duties with respect to a plan in accordance with the documents and instruments governing the plan. ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

84. Blue Cross breached these fiduciary duties under ERISA § 404(a)(1)(A) and (D), 29 U.S.C. § 1104(a)(1)(A) and (D), by placing its interests ahead of class members' interests and by administering their claims in a manner that caused class members to pay more in coinsurance than permitted under the governing plan documents and then retaining the difference for itself.

85. Blue Cross also breached its duty to disclose and inform by: (i) issuing EOBs to class members that purported to show Blue Cross was calculating their benefits and coinsurance obligations as a percentage of the SMA (i.e., the charges remaining after the discounts it had negotiated with the providers) when in fact it was not; and (ii) by failing to inform class members about the discounts or payments it receives from providers when it knew that such

information was material to class members and that its silence would be harmful to their financial interests.

86. Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), Plaintiff and the class are entitled to appropriate equitable relief to redress Blue Cross's misconduct.

COUNT FIVE

Claim for Benefits and Other Relief to Enforce and Redress Violations of Plan Terms (Brought Against the Plan)

87. Plaintiff incorporates by reference the allegations contained in the previous paragraphs of this complaint as if fully set forth herein.

88. ERISA provides that a participant or beneficiary may bring a civil action to recover benefits due to her. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

89. ERISA further provides that a participant or beneficiary may bring a civil action to enforce her rights under the terms of the plan, to clarify her rights to future benefits under the plan, to enjoin any act or practice which violates the terms of the plan, or to obtain other appropriate equitable relief to enforce any provisions of the plan. ERISA §§ 502(a)(1)(B) and 502(a)(3), 29 U.S.C. §§ 1132(a)(1)(B) and 1132(a)(3).

90. The Plan provides that benefits for in-network services are to be payable at a percentage of the SMA, which is the amount that Blue Cross has negotiated with in-network providers as payment in full for their services.

91. In connection with certain in-network claims, the Plan did not pay benefits at the percentage of the SMA set forth in the Plan document. Instead, Blue Cross calculated participants' and beneficiaries' coinsurance obligations as a percentage of an amount greater than the SMA, with the result that the participant paid more in coinsurance and received less in benefits than she should have under the Plan.

92. Plaintiff and those class members who are participants and beneficiaries of the Plan are entitled to: (i) recover the benefits due to them under the terms of the Plan; (ii) enforce their right to have their benefits and coinsurance obligations calculated in accordance with the Plan; (iii) clarify their rights to have future benefits and coinsurance obligations calculated in accordance with the Plan; (iv) enjoin Blue Cross from administering claims in a manner contrary to the Plan; and (v) to obtain other appropriate equitable relief, including but not limited to the reprocessing of their claims in accordance with the Plan terms and an accounting thereof.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff on behalf of herself and the class prays for relief as follows:

A. The certification of this action as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure with Plaintiff as the class representative, and the appointment of the undersigned attorneys as counsel for the class;

B. A declaration that the provisions in class members' plans providing that benefits are payable as a percentage of the Schedule of Maximum Allowances require Blue Cross to calculate benefits, coinsurance obligations, and lifetime maxima based on the amounts in-network providers have agreed to accept as payment in full for their services after all discounts, payments, refunds or other allowances to Blue Cross, and not some other amount;

C. An injunction or other equitable relief requiring Blue Cross to recalculate Plaintiff's and class members' benefits, coinsurance obligations, and lifetime maxima based on the amounts set forth in their plan, and not some other amount, and to issue new EOBs in connection with the recalculations;

D. Restitution or other relief to redress Blue Cross's prohibited transactions;

E. Disgorgement and an accounting for profits;

F. Prejudgment interest on all amounts recovered at the maximum rate allowable by law;

G. An award to Plaintiff and the class of the expenses of this suit, including costs, reasonable attorneys' fees and expert fees, and other disbursements;

H. In addition and/or in the alternative, all relief to which Plaintiff and the Class may be entitled under the facts and law, however denominated or labeled, pursuant to Fed. R. Civ. P. 54(c) or otherwise; and

I. Such other and further relief as this Court may deem just, equitable and proper.

Respectfully submitted,

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Dated: July 31, 2008

AEE

EXHIBIT 1

PEOPLES ENERGY CORPORATION

MEDICAL AND DENTAL PLAN

(Effective January 1, 2002)
Except as Specifically Provided

EXHIBIT 1

EXHIBIT 1

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I. PROVISIONS RELATING TO ELIGIBILITY

A. EMPLOYEE ELIGIBILITY

All active full-time Employees are eligible to subscribe for Plan coverage on their first day of work. Part-time employees are eligible for coverage for which they must pay the monthly contribution payable by full time employees plus an incremental premium, as determined annually, based on their scheduled weekly hours. Temporary employees are ineligible for coverage.

B. DEPENDENT ELIGIBILITY

Each person who is a dependent of an eligible Employee shall become eligible for Plan or HMO coverage either on the date the Employee becomes eligible or the date the person becomes a dependent, whichever is later.

The term "dependent" shall include only the following provided they are not covered as Employees under this Plan:

The lawful spouse of an Employee, while not divorced or legally separated from the Employee;

The unmarried natural or adopted child or children of an Employee, from birth until age twenty-three, provided the child is not employed on a regular full-time basis and continues to be dependent on the Employee for support. Full-time summer employment will not, however, disqualify a full-time student from coverage, subject to the age 23 limitation;

The word "child" also includes stepchildren, foster children and "other" children who depend on the Employee for support and live with the Employee in a regular parent-child relationship. Additionally, the word "child" includes any child of an Employee who is designated as an "alternate recipient" under an order determined by the Retirement and Benefit Plans Committee to be a "qualified medical child support order" as described in Section 609(a) of the Employee Retirement Income Security Act of 1974, (ERISA) as amended. "Other" children shall be limited to children for whom the Employee has been appointed as a guardian by order or judgment of a court of competent jurisdiction and for whom satisfactory evidence of guardianship and residency of the child with the

Employee is provided by the Employee, except that "Other" children shall also include any individual who has not attained age 18 and who is placed for adoption with an Employee.

Unmarried dependent children who are mentally retarded or physically handicapped who were covered by the Plan or HMO prior to age twenty-three will be deemed to be dependents following attainment of that age provided they are incapable of self support and continue to be dependent on the Employee for support and maintenance. In order for coverage to continue, the Employee must submit to the Preferred Provider Organization (PPO) Claims Administrator due proof of incapacity within two months prior to the child's twenty-third birthday. If the Employee fails to submit such proof, coverage for the dependent child will terminate upon the child's attainment of age twenty-three. The coverage may be continued for as long as the Employee or spouse remains covered and the child's incapacity continues. The PPO Claims Administrator does, however, have the continuing right to request proof of mental retardation or physical handicap status at any reasonable time after the initial proof is submitted.

C. ELIGIBILITY FOR EMPLOYEES AND DEPENDENT SPOUSES AFTER AGE 65

Employees who remain actively employed beyond their 65th birthday and their dependent spouses may continue to receive benefits under the Plan irrespective of Medicare eligibility. The Plan will be considered the primary provider of health care coverage for the Employee and/or dependent spouse and Medicare will coordinate, unless the Employee or dependent spouse makes a written election to the contrary. However, the Plan will only be considered the primary provider of health care coverage for a dependent spouse, when the spouse is not eligible for group coverage under another employer sponsored plan. Should the Employee or dependent spouse make a written election that Medicare is to be primary, the Plan cannot coordinate with Medicare in any way for either the Employee or a Medicare eligible dependent spouse.

D. ELIGIBILITY AFTER RETIREMENT

In order to be eligible for continuation of coverage at retirement, the Employee must have completed 10 years of continuous service after attaining age 40. Notwithstanding the foregoing, any Employee that elected to retire

under the provisions of Appendix I, Special Retirement Offer, of the Peoples Energy Corporation Retirement Plan will be deemed to have satisfied the eligibility criteria for continuation of coverage at retirement. If this condition is met, Employees and their eligible dependents may continue coverage after retirement, provided the required contributions are made. Coverage for the Retiree or spouse can continue until the Retiree or spouse becomes eligible for Medicare or other coverage through State or Federallegislation. Coverage for eligible dependent children also continues as long as either the Retiree and/or spouse is covered under this Plan or the Medicare Supplement Plan.

A Retiree who marries while still covered under this Plan may enroll his spouse as long as the spouse is not eligible for Medicare or other coverage available through State or Federal legislation. Stepchildren may also be enrolled provided they meet dependent qualifications.

A Retiree who marries after he is no longer covered under this Plan may not enroll any new dependents unless the dependent is a natural child resulting from the marriage of the Retiree and his covered spouse.

E. OTHER ELIGIBILITY PROVISIONS

1. Marriage Between Employees

If both spouses are eligible Employees under this Plan, each can be covered no more than once by this Plan. An individual may not be covered as both an employee and a dependent under this Plan.

Eligible dependent children resulting from a marriage between Employees may be covered as dependents of only one of the Employees. This provision applies even if one Employee elects to participate in a Health Maintenance Organization (HMO) and the other elects PPO coverage.

2. Effect of Participation in a Health Maintenance Organization (HMO)

Eligible Employees who elect coverage under an HMO and their dependents shall continue to be eligible for dental benefits provided under the Plan. However, all medical coverage provided by Claims Administrators under the Plan shall terminate as of the effective date of HMO coverage for the covered Employee and dependents and the Extension of Benefits provision contained in the Plan shall not be

applicable.

An Employee or dependent who would otherwise be eligible for Plan benefits and whose HMO coverage terminates, either as a result of moving out of the HMO's service area or the discontinuance of care by the HMO, shall have the right to re-enroll into the Plan immediately. All conditions of the Plan regarding enrollment and contributions must be met.

An annual re-enrollment period is also held each year to allow eligible Employees to change between HMO coverage and PPO coverage under the Plan without restriction.

3. Notification Procedure for Changes in Dependency Status

Only those eligible dependents whose name and birth date are on record with the Employer will be covered by the Plan. A covered Employee who acquires an eligible dependent must make application immediately to assure coverage by providing the dependent's name and birth date. The Employer reserves the right to request evidence of dependent and marital status. Coverage on such dependents shall take effect as provided in the Effective Date of Coverage section.

A covered Employee must also notify the Employer immediately when a previously covered dependent no longer qualifies under the term "dependent."

II. EFFECTIVE DATE OF COVERAGE

A. APPLICATION BEFORE ELIGIBILITY DATE

If application is made on or before the date the Employee and/or dependent becomes eligible for the Plan, coverage shall be effective on the date of eligibility subject to the Effective Date Proviso below.

B. APPLICATION WITHIN 31/60 DAYS OF ELIGIBILITY DATE

If the application for the Employee is made within 31 days from the date of eligibility, or, if the application for the dependent is made within 60 days of eligibility, the elected PPO or HMO coverage will take effect on the date of application, subject to the Effective Date Proviso. An Employee's newborn dependent's coverage will take effect at birth provided such newborn's application is made within 60 days of birth.

C. APPLICATION MADE MORE THAN 31/60 DAYS AFTER ELIGIBILITY DATE

If application is not made within the time period provided in Section II B above, an Employee or dependent must wait until the next annual re-enrollment period to apply for coverage, unless a Special Enrollment provision applies, as described in Section II E below.

D. EFFECTIVE DATE PROVISO

If an Employee is not actively at work on the last work day immediately preceding the applicable effective date, the effective date for both the Employee and dependents shall be deferred until the date the Employee resumes work.

E. SPECIAL ENROLLMENT

Employees and dependents may enroll in the Plan through Special Enrollment if:

1) They have previously declined coverage and then lost coverage under another plan, and

-- the Employee or dependent was covered under another plan at the time coverage under this Plan was offered but declined; and

-- written declination of coverage was provided at the time; and

-- if the prior coverage was COBRA coverage, that coverage has been exhausted, or if the loss of coverage resulted from a loss of eligibility for coverage (e.g., termination of employment, reduction in hours, divorce, etc.) or the cessation of Employer contributions (but not merely an increase in Employee contributions); and

-- the participant provides a statement from the previous plan stating the participant's ineligibility or loss of coverage; then

-- coverage will be effective on the first day of the month following the date the completed request for enrollment is received.

or

2) They have previously declined coverage and then have added a dependent through marriage, birth, adoption or placement for adoption, then coverage will be effective on the date of one of these events.

The request for enrollment must occur within 30 days of the event.

III. MONTHLY PARTICIPANT CONTRIBUTIONS

A. CONTRIBUTION SCHEDULE

1. Medical Benefits

Effective January 1, 2002 and each January 1 thereafter, the monthly contribution rate for the Employee and Retiree categories shall be based upon the Employer's total monthly cost to provide medical benefits to covered individuals. Effective January 1, 2003, the total monthly cost will be determined separately for Nonunion Employees and Retirees and Union Employees and Retirees. The following percentage rates shall be applied to the total monthly cost to develop the monthly contribution amount for the applicable Union and Nonunion Employee or Retiree coverage category. Medical coverage categories shall be the same as those listed under "Dental Benefits" in this Section III A.

Percentage Contribution

	Nonunion			Union
Effective January 1	PSE & Officers	Associate & Technical and Unclassified	Retirees	Actives & Retirees
2003	**15.0%**	**13.0%**	**16.0%**	**13.0%**
2004	**17.5%**	**14.5%**	**20.5%**	**14.5%**
2005	**20.0%**	**16.0%**	**25.0%**	**16.0%**

2. Dental Benefits

The following schedule of monthly contribution dollar amounts by coverage category shall apply effective January 1, 2002 for Union Employees and Retirees and effective January 1, 2003 for Nonunion Employees and Retirees

	Union*	Nonunion**
Employee/Retiree Only	**$ 6.00**	$8.00
Employee/Retiree and One Dependent	**12.00**	16.00
Employee/Retiree and Two or More Dependents	**18.00**	24.00

Spouse or Child of a Retiree	**6.00**	8.00
Spouse and Child(ren) of a Retiree	**12.00**	16.00
Spouse of a Deceased Employee/Retiree	**6.00**	8.00
Spouse and Child(ren) of a Deceased Employee/Retiree	**12.00**	16.00

*Effective January 1, 2002
**Effective January 1, 2003

3. HMO Coverage

Effective January 1, 2002 and each January 1 thereafter, the monthly contribution rate for the Employee and Retiree categories shall be based upon the gross premium, as agreed to by the applicable HMOs. The contribution amount for Employees shall be determined by applying a percentage rate of 20 percent to the gross coverage premium for each category. The contribution amount for Retirees shall be determined by applying a percentage rate of 25 percent to the gross coverage premium for each category. HMO coverage categories shall be the same as those listed under "Dental Benefits" in this Section IIIA.

B. PRE-TAX CONTRIBUTION ELECTION

An Employee may, by completing and submitting an election form to the Employer, elect to have a portion of the compensation payable by the Employer to the Employee applied on a pre-tax basis to defray:

1. any Employee monthly contributions required for coverage hereunder for medical and/or dental benefits.

C. TIME OF ELECTION

The election referred to in Paragraph B above shall be made on such form, in such manner and submitted to the Employer at such time as the Employer may from time to time determine; provided, however, that such completed election form shall be submitted and the election made during the periods set forth in this Paragraph C:

1. With respect to each calendar year, any Employee who has made such an election effective for the preceding calendar year may take no action upon being advised of the annual opportunity (and said annual opportunity having passed) to elect out of the Pre-Tax Contribution Program with respect to this Plan and shall, as of the December 15 preceding the first day of the next calendar year, be deemed to have made an election to continue participation in the Plan for the next calendar year.

2. With respect to each calendar year, Employees who are eligible to participate in the Plan on the first day but who had not elected to participate in the preceding calendar year shall submit the request and make the election during an enrollment period established by the Employer which will end no later than the December 15 immediately preceding the first day of such calendar year.

3. For those Employees who first become eligible to participate in the Plan during a calendar year, requests shall be submitted and elections made during the period immediately preceding the date the Employee will become eligible to participate hereunder.

4. For those Employees who are eligible to enroll in the Plan due to Special Enrollment, as defined in Section II E, requests for elections should be made at the time of Special Enrollment, the election becoming effective as of the date of coverage.

D. IRREVOCABILITY OF ELECTION

An Employee's election under Paragraph C above shall be revocable at any time prior to December 15 of the calendar year immediately preceding the calendar year to which the revocation pertains. An Employee's election shall become irrevocable as of December 15 of the calendar year immediately preceding the calendar year to which it pertains or, in the case of a newly eligible Employee, the date on which the newly eligible Employee becomes eligible hereunder during said calendar year and shall remain in effect for the remainder of that calendar year; provided, however, that an Employee may revoke his or her election during the calendar year and make a new election with respect to the remainder of such calendar year on account of and consistent with a change in status. For purposes of this preceding sentence, "change in status" shall include marriage, divorce, death of the spouse or a dependent child, birth or adoption of a dependent child or the termination or commencement of employment of the spouse of the Employee and, effective October 1, 1998, loss of coverage under another plan, including exhaustion of COBRA coverage, and such other circumstances as the Employer may in its

sole discretion determine consistent with applicable regulations and general participation eligibility standards. The amount of compensation elected by an Employee to be applied by the Employer to defray the monthly Employee contributions as described in Paragraph B above shall reduce the amount of compensation otherwise payable by the Employer to the Employee during the calendar year. In no event shall the amount of compensation elected by an Employee to be so applied by the Employer be:

1. refunded or otherwise paid to the Employee directly or indirectly; or

2. carried over or applied to provide benefits in any subsequent calendar year; or

3. used to purchase or provide a benefit to the Employee under any other plan of the Employer.

IV. MEDICAL PLAN BENEFITS

A. BODILY INJURY, DISEASE OR PREGNANCY

The following benefits will be administered by the PPO Claims Administrator, and references to the Claims Administrator in this Section IVA shall be deemed to mean PPO Claims Administrator.

1. Inpatient Care at a Recognized Hospital

Expenses related to inpatient care at a recognized Hospital for bodily injury, disease or pregnancy shall be payable under the terms of this Plan for covered Employees and their dependents as follows:

Payable at 90% (for Union Employees and Retirees) and 80% (for Nonunion Employees and Retirees) of the Claims Administrator's Schedule of Maximum Allowances following satisfaction of a deductible for In-Network charges or at 70% (for Union Employees and Retirees) and 60% (for Nonunion Employees and Retirees) of Reasonable and Customary charges following satisfaction of a deductible for combined In-Network and Out-of-Network charges:

a. Daily room and board charges without limitation as to the maximum number of days.

b. Charges for hospital services or supplies in the following list shall be considered covered expenses to the extent that the charges are

either within the Claims Administrator's Schedule of Maximum allowances for In-Network, or, if Out-of-Network, Reasonable and Customary:

- operating, recovery, delivery & nursery room charges
- anesthesia
- drugs and dressings
- oxygen
- x-rays
- laboratory tests
- intravenous fluids
- physical therapy
- cobalt and radium treatments
- private duty nursing by a registered nurse or licensed practical nurse when prescribed by and under the direction of the attending Physician.
- blood not provided under a cooperative blood replacement program and the cost of administration of blood.
- mammograms, beyond the age-based schedule in Section IVA3n, as Medically Necessary.

c. Charges for medical treatment or surgery performed by a Physician or assistant surgeon

d. Charges for obstetrical services (delivery).

Under no circumstances shall it be within the "Schedule of Maximum Allowances" or "Reasonable and Customary" to cover less than 48 hours of hospital confinement for normal delivery and 96 hours of hospital confinement for caesarian delivery unless actual confinement for a normal or caesarian delivery was less than the 48 or 96 hour period, respectively, at the decision of the patient andPhysician.

2. Inpatient Care - Hospital Utilization Review

The hospital utilization review program provides for an ongoing evaluation of the medical necessity of an inpatient Hospital Confinement of a covered Employee or dependent. The program operates within three distinct time periods and is administered by the Claims Administrator.

a) Pre-Admission Review

Prior to a planned, non-emergency Hospital Confinement the covered Employee or dependent or their treating Physician must notify the Claims Administrator of the proposed inpatient confinement. Such notification should include details as to the

purpose of the confinement and may be made in writing by completion of a pre-admission review form sent to the Claims Administrator ten days prior to the planned admission or by telephone at the Plan participant's option or if the time frame makes it impractical to submit the form in advance. In the case of an emergency inpatient Hospital Confinement, the covered Employee or dependent or treating Physician must notify the Claims Administrator by telephone within 48 hours of admission or within 72 hours if the inpatient Hospital Confinement begins on a Saturday, Sunday or legal holiday.

Once the Claims Administrator reviews the details and confirms that an inpatient confinement is Medically Necessary, the covered Employee or dependent, the treating Physician and the Hospital are advised of the number of days of inpatient confinement that the Claims Administrator deems as reasonably necessary for the treatment of the condition. The covered Employee or dependent and treating Physician may request that the Claims Administrator reevaluate or extend the number of days by promptly notifying the Claims Administrator by telephone, or in writing. The decision of the Claims Administrator will be made promptly and communicated to the covered Employee or dependent and treating Physician.

Failure to comply with the pre-admission procedure, or the results thereof, will result in a separate $400 facility charge per admission.

b) Continued Stay Review

While the covered Employee or dependent is confined in the Hospital, the Claims Administrator will contact the treating Physician at regular intervals to determine if the covered person will be discharged on schedule. If the covered Employee or dependent is not scheduled for discharge as anticipated, the Claims Administrator will request that the treating Physician provide documentation to support further stay. The Claims Administrator will approve additional days of inpatient care if there is sufficient medical evidence to warrant it. In the event the Claims Administrator and treating Physician cannot reach an agreement as to continued stay, notification is sent to the covered Employee or dependent, the treating Physician and the Hospital. The covered Employee or dependent and treating Physician may request that the Claims Administrator reevaluate and extend the number of days by promptly notifying the Claims Administrator by telephone, or in writing. The decision of the Claims Administrator will be made promptly and communicated to the covered Employee or dependent and treating Physician.

If the covered Employee or dependent elects to continue confinement beyond the number of days the Claims Administrator deems as reasonably necessary for the condition, payment will be made for such additional days only if the treating Physician provides satisfactory additional proof to the Claims Administrator that such continued stay was Medically Necessary.

c) Discharge Planning

The Claims Administrator will coordinate with the treating Physician to assure timely discharge from the Hospital focusing on providing medically appropriate care through alternate Plan benefits such as Home Health Care, Hospice Care or Extended Care Facility arrangements.

If the covered Employee or dependent elects to continue confinement despite the availability of medically appropriate alternate care choices, payment will be made for further confinement only if the treating Physician provides the Claims Administrator satisfactory additional proof that such continued stay was Medically Necessary.

3. Outpatient Care

Charges related to outpatient care for bodily injury, disease or pregnancy shall be payable under the terms of this Plan for covered Employees and their dependents as follows:

Payable at 90% (for Union Employees and Retirees) and 80% (for Nonunion Employees and Retirees) of the Claims Administrator's Schedule of Maximum Allowances following satisfaction of a deductible for In-Network charges and at 70% (for Union Employees and Retirees) and 60% (for Nonunion Employees and Retirees) of Reasonable and Customary charges following satisfaction of a deductible for combined In-Network and Out-of-Network charges:

a. Second Surgical Opinion on the need for undergoing non-urgent Surgery.

b. Outpatient operating room charges and related expenses and fees for outpatient Surgery performed by a Physician at a doctor's office or clinic, Hospital or ambulatory surgical facility.

c. Pre-Admission Testing performed within 72 hours preceding Hospital Confinement.

d. Post-Hospital Testing performed within 7 days immediately following confinement.

e. Medical care and treatment by a Physician.

f. Limited to $1,000 per person per month for **Nonunion** Employees and Retirees, private duty nursing by a registered nurse or licensed practical nurse when prescribed by and under the direction of the attending Physician. (The $1,000 limit does not apply to Union Employees and Retirees).

g. Anesthesia.

h. Oxygen.

i. Rental of iron lung, oxygen tent, hospital bed, wheelchair or similar medical equipment.

j. Initial purchase of prosthetic devices and replacements thereof only due to growth and pathological change.

k. Laboratory tests or x-ray examination (other than dental x-ray not necessitated by an injury).

l. X-ray therapy, radium therapy and radioactive isotope therapy.

m. Dental care and treatment necessitated by accidental bodily injury to sound, natural teeth while covered under the Plan.

n. Periodic mammogram screening as determined by the schedule below, subject to modification pursuant to the standard practice of the Claims Administrator.

Age of Insured	Frequency of Mammograms
35 - 39	Baseline mammogram
40 - 49	Every 2 years
50 or older	Annually

o. Cardiac rehabilitation, as Medically Necessary.

p. TMJ (temporomandibular joint) – limited to $1,000 per person per calendar year. (The $1,000 limit does not apply to Union Employees and Retirees.)

q. **Chiropractic Services – limited to $1,000 per person per calendar year. (The $1,000 limit does not apply to Union Employees and Retirees.)**

Payable at 80% for Union Employees and Retirees and Nonunion Employees and Retirees following satisfaction of In-Network deductible.

- Treatment for hearing disorders other than routine hearing exams and hearing aids, unless necessitated by damage to the ear as a result of an injury.
- Prosthetics
- Speech, physical or occupational therapy limited to $1,000 per each therapy, per calendar year for Nonunion Employees and Retirees. (The $1,000 limit does not apply to Union Employees and Retirees.)
- Durable medical equipment

B. OTHER HEALTH CARE BENEFITS

The following benefits will be administered by the PPO Claims Administrator, and references to the Claims Administrator in this Section IVB shall be deemed to mean PPO Claims Administrator.

1. Home Health Care

Charges made by a qualified Home Health Care Agency will be payable at 90% (for Union Employees and Retirees) and 80% (for Nonunion Employees and Retirees) of the Schedule of Maximum Allowances after satisfaction of the In-Network deductible or 70% (for Union Employees and Retirees) and 60% (for **Nonunion** Employees and Retirees) of Reasonable and Customary after satisfaction of the combined In-Network and Out-of-Network charges, provided the attending Physician certifies that Hospital Confinement would be required in the absence of the services and supplies furnished under a Home Health Care Plan.

Home Health Care covered charges are those charged by the qualified facility for:

a. Part-time or intermittent nursing care by or under the supervision of a registered nurse;

b. Visits by persons who have completed a Home Health Aide training course under the supervision of a registered nurse for the purpose of giving personal care to the patient and performing light household

tasks as required by the Home Health Care Plan;

c. Up to $1,000 per each therapy, per calendar year for physical, occupational and speech therapy. (The $1,000 limit does not apply to Union Employees and Retirees.)

d. Medical supplies, drugs and medicine prescribed by the attending Physician and laboratory services, but only to the extent that such services would have been provided had the Employee or dependent been hospitalized.

Payment will not be made for:

a. Services or supplies furnished to a person eligible for Medicare;

b. Custodial Care;

c. Transportationservices;

d. Expenses incurred for any period during which the Employee or dependent is not under the continuing care of a Physician;

e. Expenses otherwise excluded under Plan provisions.

Home Health Care benefits cease immediately on the day of termination of coverage under this Plan and may not be converted to an individual policy.

2. Extended Care Facilities

Charges made by an Extended Care Facility for covered services and supplies will be payable at 90% (for Union Employees and Retirees) and 80% (for Nonunion Employees and Retirees) of the Schedule of Maximum Allowances following satisfaction of the In-Network deductible, or at 70% (for Union Employees and Retirees) and 60% (for Nonunion Employees and Retirees) of Reasonable and Customary following the satisfaction of a deductible for combined In-Network and Out-of-Network charges. The confinement at such facility must, however, begin by means of a direct transfer from a Hospital in which the individual was confined for at least three days, and must be for the same condition that caused the Hospital Confinement.

Extended Care Facility covered services and supplies are defined as follows:

a. Daily room and board charges which are limited to 50% of the maximum daily room and board allowance during the Hospital Confinement and to a total of 60 days of confinement in an Extended Care Facility in eachcalendar year.

b. Nursing care (but not private duty nurse or attendant);

c. Physical, occupational and speech therapy;

d. Medical social services under the direction of a Physician;

e. Biologicals, supplies, appliances and equipment ordinarily provided by the facility for the care of patients;

f. Medical care by an intern or resident in training at a Hospital, and other diagnostic and therapeutic services furnished to Extended Care Facility patients by a Hospital;

g. Other necessary services generally provided to patients by Extended Care Facilities.

3. Hospice Care

The following Hospice care benefits will be payable for a six-month benefit period following a Physician's certification that the patient is terminally ill, with a medical prognosis of six months or less to live. Additional six-month benefit periods are allowed if the patient is alive when a six-month benefit period ends, and a Physician's certification is again provided.

Inpatient Hospice Care

Expenses related to inpatient care at a facility which is either operated as a Hospice or which provides inpatient care under arrangements made by a Hospice are payable at 90% (for Union Employees and Retirees) and 80% (for Nonunion Employees and Retirees) of the Schedule of Maximum Allowances following satisfaction of the In-Network deductible, or at 80% (for Union Employees and Retirees) and 60% (for Nonunion Employees and Retirees) of Reasonable and Customary following satisfaction of the deductible for combined In-Network

and Out-of-Network charges. For purposes of this benefit, confinement excludes any period of Custodial Care, but will include one period of Respite Care per calendar month while the terminally ill person is receiving "Hospice Home Care Services" under this Plan.

Hospice Home Care Services

Charges made for services identified as Medically Necessary or central to the Hospice approach are payable at 90% (for Union Employees and Retirees) and 80% (for Nonunion Employees and Retirees) of the Schedule of Maximum Allowances following satisfaction of the In-Network deductible, or at 80% (for Union Employees and Retirees) and 60% (for Nonunion Employees and Retirees) of Reasonable and Customary following satisfaction of the deductible for combined In-Network and Out-of-Network charges, subject to a lifetime maximum of $12,500. "Hospice Home Care Services" are the following services and supplies which are furnished by, or under arrangements made by, a Hospice; and under a written plan of Hospice care which is established and periodically reviewed by the Hospice's medical director and interdisciplinary team:

a. Part-time or intermittent nursing care provided by, or under the supervision of, a registered nurse;

b. Physical, respiratory, occupational and speech therapy;

c. Medical social services under the direction of a Physician;

d. Part-time or intermittent services of a home health aide who has successfully completed an approved training program;

e. Necessary medical supplies, the use of necessary medical appliances, drugs and medication prescribed by a Physician and laboratory services;

f. Physician's services;

g. Dietary counseling by a registered dietitian;

h. Transportation of the type needed to safely transport the terminally ill person to the place where he or she is to receive a "Hospice Home Care Service."

4. Medical Case Management

In the event a covered Employee or dependent suffers from a long term or serious illness or injury, services of the Claims Administrator's medical case management program may be made available. Under such a program, the Claims Administrator may recommend alternate medical care choices which may simply offer more efficient use of benefits offered under the Plan or in some cases involve an authorized exception to Plan provisions. Should the Claims Administrator determine that alternate medical care choices may be appropriate, contact is made and alternatives reviewed with the covered person and treating Physician. The covered Employee or dependent always retains the right to accept or reject the proposed alternate treatment.

Coinsurance percentages and deductibles will be applied in determining benefits, where applicable. Benefits paid under medical case management are included within and are not in addition to overall individual and family lifetime maximums.

5. Ambulance Charges

Expenses incurred for ground or air transportation, if Medically Necessary, by a professional ambulance service to transport a sick or injured covered Employee or dependent to and from the hospital are payable at 80% (for Union and Nonunion Employees and Retirees) after the In-Network deductible.

6. Blood and Blood Plasma

The Plan will pay a benefit equal to 80% (for **Union** and Nonunion Employees and Retirees) of the charges for blood or blood plasma not provided under a cooperative blood replacement program and for the administration of blood, after satisfaction of the In-Network deductible.

7. Vision Care Benefits

The Plan will pay a benefit equal to 90% (for Union Employees and Retirees) and 80% (for Nonunion Employees and Retirees) of the charges for routine eye examinations, eye glasses and contact lenses, limited to $200 for each covered Employee or dependent per calendar year.

Wellness Benefits

The Plan will pay a benefit, limited to $250 for each covered Employee or dependent per calendar year, for certain costs related to routine screening and preventive services as follows:

- office visits for a routine physical examination;
- immunizations (immunizations related to travel are excluded);
- routine gynecological examinations;
- routine pap smears;
- routine PSA tests;
- routine labs, x-rays, and blood tests;
- well child care for children under age 6

The Plan will provide benefits equal to 100% of the Schedule of Maximum Allowances, limited to $250 per person per calendar year, for services provided by In-Network providers.

The Plan will provide benefits equal to 70% (for Union Employees and Retirees) and 60% (for **Nonunion** Employees and Retirees) of the Reasonable and Customary charges, limited to $250 per person per calendar year, for services provided by Out-of-Network providers, after satisfaction of a deductible for combined In-Network and Out-of-Network charges.

C. PRESCRIPTION DRUG BENEFITS

Benefits under this Section IVC will be administered by the Pharmacy Benefit Manager engaged to serve as Claims Administrator.

Union Employees and Retirees may purchase prescription drugs from pharmacies participating in the Claims Administrator's network of providers for the greater of 20% of the total cost of the prescription or $5 for a generic prescription, $10 for a formulary prescription, and $25 for a brand name prescription. Such purchase is limited to a 30-day supply with one refill. Participants may continue to purchase the third and subsequent fill of the prescription from the retail pharmacy for the greater of 30% of the total cost of the prescription or $10 for a generic prescription, $20 for a formulary prescription, and $50 for a brand name prescription. Such purchase is limited to

a 30-day supply. Prescriptions may be purchased under the Claims Administrator's mail order provisions for $10 per prescription for generic drugs, $15 per prescription for formulary drugs, and $30 per prescription for brand name drugs. Such purchase is limited to a 90-day supply.

After covered expenses for Prescription Drugs paid by a covered individual reach $1,000 in any calendar year, additional covered charges for Prescription Drugs incurred by the covered individual will be reimbursed at 100% for the balance of thecalendar year.

Nonunion Employees and Retirees may purchase prescription drugs from pharmacies participating in the Claims Administrator's Network of providers for the greater of 20% of the total cost of the prescription or $10 for a generic prescription, $20 for a formulary prescription, and $30 for a brand name prescription. Such purchase is limited to a 30-day supply with one refill. Participants may continue to purchase the third and subsequent fill of the prescription from the retail pharmacy for the greater of 30% of the total cost of the prescription or $20 for a generic prescription, $40 for a formulary prescription, and $60 for a brand name prescription. Such purchase is limited to a 30-day supply. Prescriptions may be purchased under the Claims Administrator's mail order provisions for $10 per prescription for generic drugs, $20 for formulary drugs, and $30 per prescription for brand name drugs. Such purchase is limited to a 90-day supply.

Effective January 1, 2004, for Nonunion Employees and Retirees, if a generic drug is available and a brand name or formulary drug is dispensed, the participant will pay the difference between the cost of the brand name or formulary drug and generic drug cost, in addition to the applicable copay, unless the requirement was ordered by the phyisican. If the brand name or formulary drug is ordered by the physician, the member pays only the applicable copay.

D. MENTAL AND NERVOUS DISORDERS/SUBSTANCE ABUSE

Benefits under this Section IVD will be provided by the Claims Administrator engaged to provide mental and nervous disorders/substance abuse benefit coverage.

1. Inpatient Care at a Recognized Hospital

Expenses related to inpatient care at a recognized Hospital for mental and nervous disorders and/or substance abuse shall be payable as specified in Section IV, A1 and A2 for covered Employees and their dependents subject to the following limitations:

If such recognized Hospital is deemed to be an In-Network hospital, charges will be payable at 90% (for Union Employees and Retirees and 80% (for Nonunion Employees and Retirees). Charges at recognized hospitals deemed to be Out-of-Network facilities will be paid at 50% for Union and Nonunion Employees and Retirees.

For treatment of mental and nervous disorders and substance abuse, benefits will be payable for no more than 30 days of confinement in a calendar year for each covered Employee or dependent.

For treatment of substance abuse, benefits will be payable for no more than one Hospital Confinement in a lifetime, except that, with respect to an Employee, benefits will be payable for a second Hospital Confinement, provided that the second confinement begins no earlier than 5 years after the beginning of the first confinement.

2. Inpatient Care - Psychiatric/Substance Abuse Case Review

Hospital Confinements for mental and nervous disorders and/or substance abuse are subject to all elements of the hospital utilization review process, including penalties for non-compliance. Such confinements are also automatically referred to the Claims Administrator's psychiatric/substance abuse case review program. Under this program, the Claims Administrator may recommend alternate medical care choices which may offer more efficient use of benefits provided under the Plan or in some cases involve an authorized exception to Plan provisions. Should the Claims Administrator determine that alternate medical care choices may be appropriate, the alternatives are reviewed with the covered Employee or dependent and treating Physician. The covered Employee or dependent retains the right to accept or reject the proposed alternate treatment.

3. Outpatient Care

Reasonable and Customary charges for services provided by a Physician to a covered Employee or dependent in connection with

outpatient diagnosis or treatment of a mental and nervous disorder and/or substance abuse shall be payable at 100% for charges in excess of $15 per visit for In-Network care or at 50% for charges for Out-of-Network services. Charges for visits in excess of 30 per calendar year shall not be covered.

4. Annual Out-of-Pocket Maximum

After covered In-Network expenses for Mental and Nervous Disorders/Substance Abuse paid by a covered individual reach $1,000 in any calendar year, additional covered charges for Mental and Nervous Disorders/Substance Abuse incurred by the covered individual will be reimbursed at 100% for the balance of the calendar year up to the Plan maximum.

5. Maximum Lifetime Benefit

For services provided prior to January 1, 1998, the maximum lifetime benefit for inpatient and/or outpatient treatment for mental and nervous disorder and/or substance abuse, alone or in combination is limited to $60,000 per each covered Employee or dependent. This lifetime maximum is a part of, and not in addition to, the overall individual and family maximum lifetime benefits.

Benefits paid for mental and nervous disorders and/or substance abuse on January 1, 1998 and thereafter are included in the overall individual lifetime maximum, subject only to a 60-day in-patient lifetime maximum for each covered Employee or dependent.

E. MEDICAL DEDUCTIBLE PROVISION

The deductible is the amount of expenses for covered services and supplies which must be incurred by the Plan participant before specified benefits become payable. The annual deductible amount for covered medical expenses, as defined in Section IVA for Union Employees and Retirees and active Associate & Technical and Unclassified Employees, is $200 per person or $400 per family for In-Network charges and $400 per person and $800 per family for combined In-Network and Out-of-Network charges.

For Officers the annual deductible amount is $400 per person or $800 per

family for In-Network charges and $500 per person or $1,000 per family for combined In-Network and Out-of-Network charges.

For Professional, Supervisory and Executive (PSE) Employees the annual deductible amount is $250 per person or $500 per family for In-Network charges and $500 per person or $1,000 per family for combined In-Network and Out-of-Network charges.

For Nonunion retirees or survivors the annual deductible is $250 per person or $500 per family for In-Network charges and $500 per person or $1,000 per family for combined In-Network and Out-of-Network charges.

The Employee or dependent will be considered to have satisfied the deductible, if within the calendar year, charges incurred for covered medical expenses that are subject to the deductible reach the specified level. However, any covered expenses that occur in October, November and December which were used to satisfy the deductible may be carried forward and applied toward satisfaction of the deductible in the next calendar year.

Expenses for two or more family members may be used toward satisfaction of the family deductible, provided each family member's individual contribution is limited to the per-person annual deductible amount.

F. ANNUAL MEDICAL OUT-OF-POCKET EXPENSE MAXIMUM

After the annual medical deductible has been satisfied, where applicable, and coinsured covered medical expenses paid by a covered individual or family in any calendar year reach $1,500 or $2,500, respectively, for In-Network charges or $3,000 or $4,500, respectively, for combined In-Network and Out-of-Network charges, in anycalendar year, additional covered medical expenses incurred by the individual or the family are reimbursed at 100% for the balance of the calendar year up to the Plan maximum.

Out-of-pocket expenses related to dental care as well as amounts used to satisfy the deductible requirement or separate facility charge that may be imposed pursuant to Hospital utilization review, do not count toward satisfaction of the annual medical out-of-pocket maximum.

G. MAXIMUM LIFETIME BENEFITS

The maximum lifetime benefit for covered medical payments under Sections IVA and IVB, prescription drug benefits under Section IVC and payments for inpatient and/or outpatient treatment for mental and nervous disorder and/or substance abuse under Section IVD is $1,000,000 per each covered Employee or dependent. When the individual maximum has been reached, no further medical benefits are payable under this Plan.

H. EXTENSION OF BENEFITS PROVISION

The Claims Administrator will recognize hospitalization or surgical charges incurred by a covered Employee or dependent within three months immediately following the termination of coverage under the Plan provided the following conditions are met:

1. It is established that the covered Employee or dependent was totally disabled when the coverage under the Plan terminated and remained continuously disabled until the date of confinement or operation;

2. The Hospital Confinement or operation was the result of the injury or sickness causing such continuous total disability;

3. Due proof must be furnished that the confinement or operation would result in a valid claim if the Plan coverage was in force at the commencement of such confinement or at the time of such operation.

The Claims Administrator(s) will also recognize covered medical expenses other than Hospital Confinement or surgical procedure if the covered Employee or dependent is totally disabled on the date of termination of Plan benefits subject to the following conditions:

1. Total disability must be continuous from said termination date;

2. These expenses related to the disability will not be paid beyond a period of 12 months following the termination of Plan coverage;

3. This provision does not apply to Dental or Home Health Care benefits included under the Plan.

I. MEDICAL COVERAGE EXCLUSIONS

Benefits payable under the Plan shall not include or be based upon any

charge made for or in connection with any Hospital Confinement, or any examination, or any surgical, medical or other treatment, or any service or supply:

1. If the charges are in excess of the Schedule of Maximum Allowances or of what is Reasonable and Customary, as applicable;

2. Which is not Medically Necessary to the care and treatment of any injury, disease, pregnancy or mental and nervous disorder, except for a) mammogram screening in accordance with the schedule of benefits in Section IV, Sub-Section A.3., Outpatient Care, b) vision care in accordance with benefits outlined in Section IV, Sub-Section B.7., and c) wellness benefits in accordance with the benefits outlined in Section IV, Sub-Section B.8.;

3. If the charges are not considered appropriate under the administrative practices commonly adhered to by the Claims Administrator(s);

4. For a routine physical examination, except as provided in Section IV, Sub-Section B.8.;

5. Which is furnished as a result of any bodily injury or sickness arising out of or in the course of employment, or which is compensable under any Workers' Compensation or Occupational Diseases Act or Law;

6. Which is furnished without the recommendation and approval of a Physician;

7. For cosmetic surgery unless it is made necessary for the prompt repair of an accidental bodily injury while covered under the Plan;

8. For the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids, or any other care, repair, removal, replacement, or treatment of the teeth, or surrounding tissues, except, when necessitated by damage to sound natural teeth or surrounding tissues as a result of an injury which occurs while the Employee or dependent, as the case may be, is eligible under this benefit;

9. For eye examinations, eye glasses and contact lenses, for the purpose of prescribing corrective lenses or for the fitting of glasses, except as provided in Section IV, Sub-Section B.7.;

10. For hearing aids, except when necessitated by damage to the ear as a result of an injury which occurred while covered under the Plan;

11. Which is furnished by a Physician or medical practitioner who is related to the patient or lives in the patient's household;

12. For lost or stolen prosthetic devices;

13. For maintenance or repair of prosthetic devices;

14. For transportation other than local use of ambulance;

15. Which is furnished as a result of accidental bodily injury or sickness caused by a war or any act or war whether declared or undeclared, by a self-inflicted injury, by participation in a riot or by commission of a felony

16. Which is furnished, paid for or reimbursable by the government or provided through government programs for which the patient is under no legal obligation to pay;

17. To the extent that the Plan is prohibited from providing benefits for such charge by any law or regulation;

18. If the charge would not have been made in the absence of Plan benefits or for which the patient is under no legal obligation to pay;

19. Extended care or nursing home care or any other care which is primarily custodial in nature.

V. DENTAL PLAN BENEFITS

Reasonable and Customary charges related to dental care and treatment shall be payable under the terms of this Plan for covered Employees and their dependents in accordance with the Schedules listed below. Any procedure not listed is excluded except that if the procedure is for a condition for which one or more of the listed procedures would be appropriate according to customary dental practice, the maximum covered charge will be the amount allowable for the lesser charge of such listed procedures.

A. PREVENTIVE CARE SERVICES AND SUPPLIES - PAYABLE AT 90%

1. Oral examinations - initial and periodic oral exam.

2. Prophylaxis - cleaning and scaling of teeth, limited to treatment twice per calendar year.

3. Dental x-rays - supplementary bitewing x-rays, limited to twice per calendar year; periapical x-rays, single films, initial and additional (up to

12). To be considered under this Section A, such x-rays must be furnished in conjunction with other preventive care services and timing of services must comply with the stated frequency limitations.

4. Fluorides - topical application of stannous fluoride, limited to one treatment per 12 consecutive months for covered person under 18.

5. Space maintainers, limited to the initial appliance - including installation, fitting and all adjustments within 6 months of installation, and limited to covered person under age 16, and excluding all repairs to such.

6. Removable appliance therapy or fixed or cemented appliance therapy to control harmful habits, limited to the initial appliance - including installation, fitting and all adjustments within 6 months of installation, and limited to covered person under age 16.

7. Pit and fissure sealants on permanent molars for persons under age 14, but not more than once in any period of 48 months.

B. BASIC SERVICES - PAYABLE AT 80% AFTER DEDUCTIBLE

Diagnostic and Therapeutic Services

1. Dental x-rays - entire denture series including full mouth, panoramic, occlusal and intra-oral views, limited to once every 36 consecutive months; other x-rays as required for diagnosis when not associated with dental preventive care services and supplies.

2. Tests and Laboratory examinations - limited to diagnostic casts (study models) and biopsy and examination of oral tissue.

3. Oral surgery, including local anesthesia and customary postoperative treatment furnished in connection with oral surgery.

   a. Extraction of one or more teeth, including simple, surgical and impacted removal, to include the removal of completely boney impacted teeth.

   b. Alveolectomy, alveoplasty, stomatoplasty, frenulectomy, excision of pericoronal gingiva, removal of palatal or mandibular tori (exostosis), excision of hyperplastic tissue and oral tissue for biopsy, excision of a tumor or cyst or incision and drainage of an abscess or cyst, tooth replantation.

   c. Other oral surgical procedures including removal of foreign body, closure of oral and salivary fistula, sequestrectomy, maxillary sinusotomy, suture of soft tissue injury, sialolithotomy, and closure or

dilation of salivary duct.

4. Periodontics - treatment of periodontal diseases of the gums and tissues of the mouth, limited to gingivectomy, gingival curettage, and osseous surgery (post-surgical visits included), pedicle soft tissue grafts, occlusal adjustments related to periodontal problems, periodontal scaling and prophylaxis.

5. Endodontics - pulp capping, vital pulpotomy and treatment of disease of the non-vital dental pulp including apicoectomy, and medicated paste and traditional root canal therapy, and remineralization.

6. Following services and supplies:

   a. Emergency palliative treatment.

   b. General anesthetics and the administration thereof when performed in conjunction with surgical procedures only.

   c. Antibiotic drug injection by attendingDentist.

   d. Prescription drugs prescribed by attendingDentist.

   e. Visits and professional consultation by other than practitioner providing treatment.

   f. Professional dental visits after hours.

Restorative Services and Supplies

1. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations including pin retention and stainless steel crowns to restore diseased or accidentally broken teeth.

2. Recementing of crowns, inlays, and bridges.

3. Relining of dentures more than 6 months after the installation of initial or replacement denture, and limited to once per 12 month period.

4. Duplication (Rebasing) of dentures more than 6 months after installation of initial or replacement denture and limited to once per 36 month period.

5. Repair of full and partial denture, acrylic.

6. Adjustments to dentures more than 6 months after installation or if performed by other than Dentist providing appliance.

7. Tissue conditioning - more than 6 months after installation of appliance and limited to 2 treatments per arch, once per 12 month period.

C. MAJOR SERVICES - PAYABLE AT 50% AFTER DEDUCTIBLE

Restorative Services

1. Inlays, onlays, or acrylic, porcelain, or gold crown restorations, cast post and cores, to restore diseased or accidentally broken teeth.

2. Replacement of an existing inlay, onlay, or acrylic, porecelain, or gold crown restoration as described above, but if such appliance was installed while covered under this Plan, at least 5 years must have elapsed prior to its replacement or such replacement must be required as a result of accidental bodily injury sustained while covered under this Plan.

3. Repair of crowns and bridges.

4. Repair of partial dentures, metal

Prosthodontic Services and Supplies

1. Initial installation, including adjustments and relines within 6 months after installation of removable permanent partial or complete permanent dentures, but only if the denture includes replacement of a natural tooth which is extracted while the individual is covered under this Plan.

2. Initial installation of bridgework, including pontics, inlays, and crowns as abutments, but only if the bridge includes replacement of a natural tooth which is extracted while the individual is covered under this Plan.

3. Replacement of an existing removable partial or complete denture by a new removable denture. Addition of teeth to an existing removable partial denture.

   These services covered only if satisfactory evidence is presented that the replacement or addition of teeth is required to replace one or more teeth extracted while the individual is covered under this Plan, and:

   a. the replacement or addition of teeth is required to replace one or more teeth extracted after the existing removable partial denture was installed;

   b. if such denture was installed while the individual was covered under this Plan, 36 months have elapsed prior to its replacement; or

c. if necessitated by accidental bodily injury.

4. Replacement of an existing bridge by a new bridge. Addition of teeth to an existing bridge. These services covered only if satisfactory evidence is presented that the replacement or addition of teeth is required to replace one or more teeth extracted while the individual is covered under this Plan, and:

   a. the replacement or addition of teeth is required to replace one or more teeth extracted after the existing bridge was installed;

   b. if such bridge was installed while the individual was covered under this Plan, 5 years have elapsed prior to its replacement; or

   c. if necessitated by accidental bodily injury.

5. Stayplate bases - limited to front teeth only.

6. Simple stress breakers.

7. Occlusal guards related to periodontal surgery.

D. ORTHODONTIA SERVICES - PAYABLE AT 50%
(Limited to services provided to dependent children under age 19)

1. Cephalometric Film.

2. Orthodontic appliances, including impressions, installation, and all adjustments within six months of installation, for:

   a) minor treatment for tooth guidance; and
   b) interceptive orthodontic treatment.

3. Comprehensive orthodontic treatment of transitional or permanent detention, including:
   a) initial placement of orthodontic appliance; and
   b) subsequent active orthodontic treatment.

With respect to benefit payments related to initial placement of an orthodontic appliance, charges for services provided shall be deemed a covered dental charge only to the extent of 50% of the Reasonable and Customary charge for the initial banding fee.

E. DENTAL DEDUCTIBLE PROVISION

The deductible is the amount of expenses for covered services and supplies which must be incurred by the Plan participant before the specified benefits become payable.

A deductible will not be applied against charges for Preventive Care or Orthodontia Services. The combined annual deductible for expenses related to covered Basic and Major Services is $50 per person and $150 per family.

The Employee or dependent will be considered to have satisfied the deductible, if, within thecalendar year, charges incurred for covered Basic and Major Services meet the specified level. However, any covered dental expenses that occur in October, November and December which were used to satisfy the deductible may be carried forward and applied toward satisfaction of the deductible in the nextcalendar year.

F. DENTAL MAXIMUMS

The maximum annual reimbursement for covered Preventive, Basic, and Major services (combined) is $1,750 per person.

The maximum lifetime reimbursement for covered Orthodontia services is $2,000 per dependent child.

G. PRE-TREATMENT REVIEW

In the event treatment charges are expected to exceed $250, the covered Employee or dependent should request a benefit pre-determination. The Dentist completes a dental claim form prior to treatment which itemizes the dental services recommended and shows the charges for each dental service. The completed form should be sent directly to the Claims Administrator for review and determination of the amounts to be paid. The pre-treatment review serves not only as a claims processing document, but also is designed to eliminate any misunderstanding the covered Employee or dependent might have with respect to benefit coverage before treatment commences.

H. ALTERNATE COURSE OF TREATMENT

The alternate course of treatment provision of the Plan limits covered dental expenses to the least expensive, professionally adequate procedure, service or course of treatment which will produce a professionally adequate result. The determination will be made by the Claims Administrator in

accordance with their common administrative practices.

I. PATIENT - DENTIST RELATIONSHIP

The Pre-Treatment Review and Alternate Course of Treatment provisions are not intended to interfere in the patient-Dentist relationship. They are a means of informing the covered Employee or dependent and the Dentist of services covered and benefits payable under the Plan. If the covered Employee or dependent select a more costly and elaborate treatment program after the Claims Administrator informs the patient and Dentist of the benefits payable, the Plan benefit will not be increased and the patient must pay the additional cost.

J. CESSATION OF DENTAL BENEFITS

Dental benefits cease immediately on the date of termination of coverage and may not be converted to an individual policy.

K. DENTAL COVERAGE EXCLUSIONS

Benefits payable under the Plan shall not include or be based upon any charge made for or in connection with dental care and treatment:

1. If the charges are in excess of what is Reasonable and Customary;

2. Which is not Medically Necessary;

3. If the charges are not considered appropriate under the administrative practices commonly adhered to by the Claims Administrator;

4. For orthodontic services other than those provided to dependent children under age 19 under Section V, Item D;

5. Which is not furnished by a Dentist, unless the service is performed by a licensed Dental Hygienist under the supervision of a Dentist or is an x-ray ordered by a Dentist;

6. Which is cosmetic in nature;

7. For replacement of a lost or stolen appliance;

8. For initial installation of a partial or full removable denture or fixed bridgework, unless such includes replacement of a natural tooth (or teeth) extracted while covered under the Plan;

9. For appliances, restoration or procedures for the purpose of altering

vertical dimension, restoring or maintaining occlusion, splinting or replacing tooth structure lost as a result of abrasion or attrition or treatment of disturbances of the temporomandibular joint;

10. For the replacement of any crown, inlay or onlay restoration, gold filling or fixed bridge which was installed while covered under this Plan, within 5 years of the date of last replacement unless such replacement is required as a result of accidental bodily injury sustained while covered;

11. For the replacement of dentures within 36 months of the date of last replacement unless the replacement is required as a result of accidental bodily injury sustained while covered;

12. Necessitated by accidental bodily injury to sound natural teeth;

13. Arising from injuries sustained out of or in the course of employment or which is compensable under any Workers' Compensation or Occupational Diseases Act or Law.

14. Arising from injuries sustained due to war or an act of war whether declared or undeclared, self inflicted injury, participation in a riot or commission of a felony;

15. Which is furnished, paid for or reimbursable by the government or provided through government programs, provided the patient is under no legal obligation to pay.

16. If the charge would not have been made in the absence of Plan benefits or for which the patient is under no legal obligation to pay;

17. Furnished by a Dentist or Dental Hygienist who is related to the patient or lives in the patient's household.

VI. DEFINITIONS

A. ADVERSE BENEFIT DETERMINATION means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's or beneficiary's eligibility to participate in the Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

B. CLAIMS ADMINISTRATOR shall mean the organization(s) retained by the Company to provide administrative services for payment of benefits under this Plan as well as related support services.

C. COMMITTEE shall mean the Retirement and Benefit Plans Committee appointed by the Chairman of the Board to administer this Plan pursuant to Section VII, Item O.

D. COMPANY SERVICE shall mean the period of service credited to an Employee as Company Service under the Regulations for Determining Service.

E. CUSTODIAL CARE means care which is designed essentially to help a person in the activities of daily living and which does not require the continuous attention of trained medical or paramedical personnel. Such care may involve preparation of special diets, supervision over medication that can be self-administered and assistance in getting in or out of bed, walking, bathing, dressing, eating and using the toilet.

F. DENTAL HYGIENIST means a person licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of dental hygiene, and working under the direct supervision of aDentist.

F.DENTIST means a duly licensed dentist practicing within the scope of his license and any Physician furnishing dental services he is licensed to perform.

G. EMPLOYEE or EMPLOYEES shall mean and include all regular full-time and part-time management and non-management Employees in the service of the Employer who elect to be covered by this Plan. The term Employee shall also include a Retiree as long as such person is not eligible for Medicare. The term Employee does not include any employee of the Employer who is designated by the Employer as a leased employee (within the meaning of Internal Revenue Code Section 414(n)) or, an individual providing services to the Employer in the capacity of, or who was designated by the Employer as, an independent contractor.

H. EMPLOYER shall mean Peoples Energy Corporation, The Peoples Gas Light and Coke Company, North Shore Gas Company and any wholly owned or controlled corporations and subsidiaries which may adopt this Plan.

I. EXTENDED CARE FACILITY means an institution or part of an institution, not primarily for Custodial Care, which is either approved by Medicare or meets the following criteria:

1. is primarily engaged in providing inpatient skilled nursing care and related

services or rehabilitation services for sick or injured persons;

2. has policies which are developed with the advice of professional personnel, including Physicians and registered nurses, to govern the skilled nursing care and other services it provides;

3. has a Physician, a registered nurse, or a medical staff responsible for the execution of such policies;

4. requires the health care of every patient to be under the supervision of a Physician, and has a Physician available to furnish necessary medical treatment in case of an emergency;

5. maintains clinical records of all patients;

6. provides 24 hour nursing services and has at least one registered nurse full time;

7. provides appropriate procedures for the administration of drugs and biologicals;

8. has in effect a utilization review plan which provides for the review of admissions to the institution, the duration of stays there, and the professional services furnished, and;

9. is licensed pursuant to any applicable state or local law or is approved by the appropriate state or local agency as meeting the standards established for such licensing.

Whenever a multi-purpose facility provides skilled, intermediate and/or Custodial Care, only the skilled nursing care section of such institutions meet the Extended Care Facility definition.

J. HE, HIS or any other pronoun of the masculine gender shall also mean She, Her or other appropriate pronoun in the feminine gender.

K. HOME HEALTH CARE AGENCY means any institution which is licensed pursuant to any state or local law and is operated primarily for the purpose of providing skilled nursing care and therapeutic services in an individual's home and:

1. maintains clinical records on each patient and the services are under the supervision of a Physician or a registered nurse;

2. has operational policies established by a professional group including at least one Physician and one registered nurse; and

3. meets such other conditions of participation as are established under the Medicare program in the interest of the health and safety of individuals who are furnished services by such agency;

excluding any institution which is primarily involved in providing Custodial Care.

L. HOME HEALTH CARE PLAN shall mean a program for care and treatment of a covered Employee or dependent established and approved in writing by the attending Physician prior to the start of home health care services. The Physician must also certify that hospitalization would be required if home care was not provided.

M. HOSPICE means a public agency or a private organization which provides care and services for terminally ill persons and their families. The agency or organization must meet the requirements for participation under Medicare, or meet the following criteria:

1. It must provide and must make available for 24 hours a day:

   a. palliative and supportive care for terminally ill persons and their families;

   b. services which encompass the physical, psychological and spiritual needs of terminally ill persons and their families;

   c. acute inpatient care, outpatient care, home care and bereavement counseling. This care and counseling must be furnished directly by, or under arrangements made by the agency or organization.

2. It must have a medical director who is a Physician.

3. It must have an interdisciplinary team to coordinate the care and services it provides. This team must include at least one Physician, one registered nurse and one social worker.

4. It must maintain central clinical records of all patients.

5. It must be licensed or accredited as a Hospice, if the laws of the jurisdiction in which it is located provide for such licensing or accreditation.

N. HOSPITAL means only a licensed hospital (if licensing is required) operated pursuant to the law for care and treatment of sick and injured persons, including a hospital operated primarily for the care and treatment of nervous and mental conditions without facilities for major surgery. The institution must provide 24 hour nursing care and have facilities for both diagnosis and surgery except as indicated. With respect only to treatment of alcohol and drug abuse, hospital shall also mean a treatment or residential facility, or a clinic licensed or

approved for the purposes of such treatment, by the appropriate authority of the jurisdiction in which such facility or clinic is located. Hospital will not be deemed to include a hotel, rest home, nursing home, convalescent home, place for Custodial Care or home for the aged.

O. HOSPITAL CONFINEMENT shall be deemed to exist if confinement continues for 18 consecutive hours or longer; or if confinement is required because of a surgical procedure; or if a room and board charge is made.

P. IN-NETWORK means medical service rendered by a health care provider who is affiliated with the Preferred Provider Organization retained by the Company to provide health care to Employees and Retirees and their eligible dependents.

Q. MEDICALLY NECESSARY means treatment which: (a) follows good medical practice (b) is required for the medical well being of the patient and (c) is prescribed by a licensed Physician.

R. MILITARY LEAVE OF ABSENCE shall mean a leave of absence for entry into the Armed Forces of the United States, commencing on the date of the Employee's separation from the payroll of the Employer for such purposes.

S. OUT-OF-NETWORK means medical service received from health care providers not affiliated with the Preferred Provider Organization retained by the Company to provide health care to Employees and Retirees and their eligible dependents.

T. PHYSICIAN shall mean a person who is duly licensed to prescribe and administer drugs or to perform medical treatment, provided he is operating within the scope of his license. Physician shall also mean a licensed chiropractor.

U. POST-SERVICE CLAIM means any claim for a benefit that is not an Urgent Care or a Pre-Service Claim.

V. PRE-ADMISSION AND POST HOSPITAL TESTING means laboratory tests or x-ray examinations for diagnostic purposes performed in connection with inpatient surgery or medical treatment provided:

1. the x-ray and/or laboratory tests are given in connection with a scheduled Hospital Confinement which in the case of pre-admission testing is to commence within 72 hours subsequent to the testing, or in the case of post-hospital testing within 7 days immediately following confinement;

2. the tests must be performed in the same Hospital in which the confinement takes place or in a certified laboratory or clinic; and

3. the tests must be ordered by the same Physician who hospitalizes the

patient.

If the Hospital admission is postponed or cancelled following pre-admission testing, benefits will be payable upon receipt of a satisfactory explanation from the attendingPhysician.

W. PREFERRED PROVIDER ORGANIZATION (PPO) means that organization retained by the Company to provide health care services at negotiated prices.

X. PRE-SERVICE CLAIM means any claim for a benefit with respect to which the terms of this Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Y. REASONABLE and CUSTOMARY - A charge shall be considered reasonable and customary to the extent that it does not exceed the general level of charges being made by Physicians or other providers of similar standing in the locality where the charge is incurred for like or comparable treatment, services or supplies. The term "locality" means a county or such greater or lesser area as is necessary to establish a representative cross section of persons or other entities regularly furnishing the type of treatment, services or supplies for which the charge is made.

Z. RESPITE CARE means a period of inpatient care of five consecutive days or less which is furnished to a terminally ill person:

1. under a plan of Hospice care;

2. by a Hospital;

3. on an intermittent, non-routine and occasional basis; and

4. to provide respite from the care of a terminally ill person for those persons who customarily provide such care.

AA. RETIREE shall mean a person who is retired from active service with the Employer pursuant to the provisions of the Retirement Plan or Service Annuity System, and shall not be applicable to Employees who upon termination of service prior to normal retirement date become vested with a right to become eligible for a service annuity under the Retirement Plan or Service Annuity System

BB. SCHEDULE OF MAXIMUM ALLOWANCES shall mean those charges for medical services as negotiated by the Preferred Provider Organization for In-Network services.

CC. SECOND SURGICAL OPINION - Before undergoing non-urgent elective surgery recommended by a Physician, the patient obtains a second opinion on

the need for such surgery from another physician. The term "non-urgent" refers to surgery which can be postponed without undue risk to the patient.

DD. SURGERY shall mean: (a) a cutting operation; (b) suturing of a wound; (c) treatment of a fracture; (d) reduction of a dislocation; (e) x-ray or radium therapy if used in lieu of a cutting operation for the purpose of removing a tumor, tonsils, or excessive lymphoid tissue; (f) diagnostic and therapeutic endoscopic procedures; (g) injection treatment of hemorrhoids or varicose veins.

EE. URGENT CARE means any claim for medical treatment where denial of such care –:

1. Could seriously jeopardize the life or health of the claimant or their ability to regain maximum function, or,

2. In the opinion of a Physician with knowledge of the medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is a claim involving Urgent Care within the meaning of this section is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a Physician with knowledge of the claimant's medical condition determines is a claim involving Urgent Care within the meaning of this section shall be treated as a claim involving Urgent Care for purposes of this definition.

VII. GENERAL PROVISIONS

A. ASSIGNMENT OF BENEFITS

The Claims Administrator may, at its option, make payment of benefits for any or all charges directly to a Hospital, facility or Physician rendering such service unless the submitted charge is marked by the provider as "paid" or is accompanied by other evidence of payment. All payments made under the Plan shall be in accordance with the above provisions except that in the event the Claims Administrator determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, the Claims Administrator may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee to the lawful spouse or relative by blood or any other person or institution determined by the Claims Administrator to be equitably entitled thereto. In the case of death of the Employee before all amounts payable under the Plan have been paid, the Claims Administrator may

pay any outstanding claims to any person or institution determined by the Claims Administrator to be equitably entitled thereto. Payments made in accordance with this provision shall discharge the Plan's obligation with respect to the amount of benefits so paid.

B. COBRA CONTINUATION COVERAGE

1. Each Employee or dependent may elect continuation coverage in the event coverage under this Plan would terminate on account of a Qualifying Event as defined below:

   (a) termination of employment by the covered Employee for any reason other than gross misconduct;

   (b) reduction in the hours of employment by the Employee;

   (c) death of a covered Employee;

   (d) divorce or legal separation of a covered Employee or provided the Employer is given notice of such event within 60 days after its occurrence;

   (e) a dependent child ceases to be a dependent as defined under the Plan provided the Employer is given notice of such event within 60 days after its occurrence; or

   (f) with respect to a Retiree, the commencement of a bankruptcy proceeding under Title 11, United States Code, with respect to the Employer.

2. For purposes of this Section, continuation coverage for each covered Employee or dependent, or child of such Employee or dependent, due to birth, adoption or placement for adoption while the Employee or dependent was eligible for continuation coverage shall be the same coverage as in effect on the date of the Qualifying Event, as such coverage may from time to time be amended or terminated. Any Employee or dependent electing continuation coverage shall, however, be entitled to change between coverage under Article IV and an HMO option during any open enrollment period in the same manner as any active Employee.

3. Upon the occurrence of a Qualifying Event, the Employer shall notify each affected Employee or dependent of the opportunity to elect continuation coverage hereunder. In order to elect continuation coverage, the Employee or dependent:

(a) must appropriately complete the prescribed form and deliver it to the Employer within 60 days of receipt of such notice or if later, within 60 days of the date the coverage under the Plan would otherwise terminate on account of the Qualifying Event; and

(b) pay the cost of such continuation coverage (as determined by the Employer) within 45 days of election for the period from the date on which coverage under the Plan would otherwise terminate through the month in which the election to maintain continuation coverage is received by the Employer.

Failure to elect continuation coverage on a timely basis and to pay the cost shall terminate the right to elect continuation coverage.

4. In the event that an Employee or dependent declines coverage, such person may nonetheless elect to maintain continuation coverage by delivering an appropriately completed prescribed form, to the Employer and paying the cost of such coverage pursuant to paragraph 3 above. The continuation coverage shall, however, be effective only from the date of receipt of such election by the Employer and the period for which payment is required shall be measured from that date if later than the date specified in paragraph 3.(b).

5. Continuation coverage shall terminate upon the earliest of the following dates:

(a) termination of all group health plans maintained by the Employer;

(b) the end of the month for which the last full contribution has been made by the Employee or dependent;

(c) the date the Employee or dependent is or becomes covered under any other group health plan as an employee or otherwise, unless the new coverage excludes a preexisting condition of the Employee or dependent;

(d) the Employee or dependent becomes enrolled in Medicare;

(e) 18 months from the date of a Qualifying Event described in paragraph 1(a) or (b), provided, however, this period may be extended for an additional 11 months if the Employee or dependent notifies the Employer before the end of 18 months that the Employee or dependent was determined to be eligible for disability benefits under the Social Security Act as of the date of the original Qualifying Event.

In the event a qualified beneficiary is disabled during the first 60 days of COBRA coverage, benefits may be provided for a total of 29

months if the following conditions are met:

(i) the initial Qualifying Event must have been a termination of employment or a reduction in hours of employment, and

(ii) the qualified beneficiary must be determined to have been disabled, as defined by Social Security, within the first 60 days of COBRA coverage, and

(iii) a copy of the determination of disability has been provided to the Employer within 60 days after the determination is issued and before the expiration of the initial 18 month COBRA coverage period.

(f) 36 months from the date of a Qualifying Event as described in paragraph 1(c), (d) or (e); or

(g) with respect to a Qualifying Event described in 1(f), the date of death of the Retiree, and for his/her dependents, 36 months after the date of death of the Retiree.

6. An individual whose continuation coverage expires by reason of subparagraph 5(e), (f) or (g) above shall be entitled for a period of 180 days after such termination to elect to enroll under any conversion health plan which may then be available under the Plan.

7. If during the period that continuation coverage is in effect a Qualifying Event described in paragraph 1(c), (d) or (e) occurs, then each affected dependent shall again be entitled to elect continuation coverage hereunder. The period of such continuation coverage shall not, however, extend beyond 36 months after the date of the first Qualifying Event.

C. COORDINATION OF BENEFITS

All benefits provided under this Plan for medical and dental care and treatment are subject to this provision.

1. Definitions

(a) "This Plan" means the Medical and Dental Plan

(b) "Other Plan" means the following plans providing benefits or services for or by reason of medical or dental care and treatment: (1) group insurance coverage, (2) Employer sponsored HMO or other prepayment coverage on a group basis, (3) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans and (4) any coverage under governmental programs, or any coverage

required or provided by any statute.

(c) "Allowable Expense" means any necessary, reasonable and customary item of health care expense for which at least part of the expense is covered under at least one of the plans covering the person for whom claim is made.

(d) "Claim Determination Period" means calendar year or, if shorter, that portion of a calendar year during which a person is covered under this Plan.

2. Effect on Benefits

(a) This provision shall apply in determining benefits if a person covered under This Plan is also covered under one or more Other Plans, and the sum of the benefits payable under This Plan together with the benefits payable under all Other Plans exceeds the covered person's Allowable Expenses during any Claim Determination Period. In this instance, the benefits that would otherwise be payable under This Plan with respect to such person during the Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all benefits payable for Allowable Expenses under all Other Plans shall not exceed the total of such Allowable Expenses. Benefits payable under another plan include the benefits that would have been payable had claim been duly made therefore.

(b) The rules establishing the order of benefit determination if a person is covered under two or more plans are as follows:

i. The benefits of the plan covering the person as an active Employee shall be determined before the benefits of the plan covering the person as an inactive or retired Employee;

ii. The benefits of a plan covering the person other than as a dependent shall be determined before the benefits of a plan covering such person as a dependent;

iii. The benefits of the plan covering the person as a dependent of the person whose birthday falls earlier in the year shall be determined before the benefits of the person whose birthday falls later in the year;

iv. In the event the Other Plan does not provide for determining benefits in accordance with the procedure in (3), the benefits of the plan covering the person as a dependent of a male person shall be determined before the benefits of the plan covering the

person as a dependent of a female person;

v. When (i), (ii.), (iii) or (iv) above fail to establish an order for benefit determination, then the benefits of the plan covering the person for the longer period of time shall be determined first.

Such rules shall be automatically superseded to the extent necessary to conform to regulatory requirements or common insurance industry practices.

(c) If the Other Plan(s) do not contain provisions establishing the same order of benefit determination rules, the benefits under those plans will be determined before the benefits under This Plan.

3. Right to Receive and Release Necessary Information

For the purpose of determining the applicability as well as to assist in the implementation of this provision, the Claims Administrator may release to, or obtain from, any other insurance company or other organization or person, any claim information which the Claims Administrator deems to be a necessity for such purposes. Any person claiming benefits under This Plan shall furnish to the Claims Administrator such information as may be necessary to implement this provision.

4. Right of Recovery

Whenever payments for Allowable Expenses have been made by the Claims Administrator in a total amount which is in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the Claims Administrator shall have the right to recover such overpayments from any other person, any other insurance companies or any other organizations.

5. Facility of Payment

The Claims Administrator has the right to pay to any other organization an amount it shall determine to be warranted if payments which should have been made under This Plan in accordance with this provision have been paid under any Other Plans.

D. COVERAGE EXTENDED TO DEPENDENTS AFTER DEATH OF AN EMPLOYEE

Continued coverage under the Plan will be extended to covered dependents following the death of the Employee subject to the following:

1. If the Employee had completed less than 10 years of service at the time of death, Plan benefits will continue to be extended to covered dependents

until the first of the month following the 90-day period that begins with the date of the Employee's death, provided the required contributions are made.

2. If the Employee had completed 10 or more years of service at the time of death, Plan benefits will continue to be extended to covered dependents beyond the 90-day period specified above, subject to required contributions, unless the lawful spouse is employed and eligible for that employer's medical coverage or is eligible for Medicare or coverage of any kind through State or Federal legislation. Once qualified for continuation, coverage will be extended until such lawful spouse remarries, becomes employed and eligible for that employer's medical coverage or later qualifies for Medicare or coverage of any kind through State or Federal legislation. Coverage for dependent children of a deceased Employee may continue only for as long as they meet the dependent definition and the Employee's surviving spouse remains covered under the Plan.

Coverage under the Plan, beyond that provided by 1 or 2 above, would be subject to the COBRA Continuation Coverage provisions of this Plan, as defined in Section VII B.

E. COVERAGE EXTENDED TO DEPENDENTS AFTER DEATH OF A RETIREE

Continued coverage under the Plan will be extended to covered dependents following the death of a Retiree subject to the following:

1. If the Retiree had completed less than 10 years of service at the time of retirement, Plan benefits will continue to be extended to covered dependents until the first of the month following the 90-day period that begins with the date of the Retiree's death, provided the required contributions are made.

2. If the Retiree had completed 10 or more years of service at the time of retirement, Plan benefits will continue to be extended to covered dependents beyond the 90 day period specified above, subject to required contributions, unless the lawful spouse is employed and eligible for that employer's medical coverage or is eligible for Medicare or coverage of any kind through State or Federal legislation. Once qualified for continuation, coverage will be extended until such lawful spouse remarries, becomes employed and eligible for that employer's medical coverage or later qualifies for Medicare or coverage of any kind through State or Federal legislation. Coverage for dependent children of a deceased Retiree may continue only for as long as they meet the dependent definition and the Retiree's surviving spouse remains covered under this Plan or the Medicare Supplement Plan.

Coverage under the Plan, beyond that provided by 1 or 2 above, would be subject to the COBRA Continuation Coverage provisions of this Plan, as defined in Section VII B.

F. DISCONTINUANCE OF COVERAGE OF EMPLOYEES

The benefits of an Employee covered under the Plan shall cease automatically on the earliest of the following dates:

1. The date of termination of employment. For the purpose of benefits under the Plan, employment terminates on the last day of the calendar month in which the Employee ceases active work. Absence from work due to sickness, injury, temporary lay-off, non-military leave of absence or retirement shall not be considered termination of employment;

2. The last day of the month during which an Employee enters upon a military leave of absence. Dependents who are covered under the Plan at the beginning of such military leave of absence will continue to be covered for the period of the leave at the Employer's expense;

3. The date of expiration of the period for which the last contribution for such coverage was made by the Employee to the Employer;

4. The date of termination of such coverage under the Plan;

5. The date of termination of this Plan.

G. DISCONTINUANCE OF COVERAGE OF DEPENDENTS OF EMPLOYEES

The benefits of a dependent of an Employee covered under this Plan shall cease automatically on the earliest of the following dates:

1. the date the dependent becomes eligible as an Employee under the Plan;

2. In the case of a spouse, the date of divorce or legal separation from the Employee;

3. In the case of a child, the date the child attains the age of 23, or if prior to age 23, the date of the child's marriage or the date the child is no longer dependent upon the Employee for support. Coverage will, however, be extended beyond age 23 if the child meets the eligibility criteria for continued coverage due to mental retardation or physical handicap and submits proof in compliance with Plan provisions relating to eligibility. If the Employee fails to submit such proof, coverage for such dependent will terminate upon the attainment of age 23;

4. The date the Employee's Plan coverage terminates, except as otherwise provided under the provision entitled "Coverage Extended to Dependents After Death of an Employee";

5. The date of expiration of the period for which the last contribution for such coverage was made by the Employee to the Employer;

6. The date of termination of such coverage under the Plan;

7. The date of termination of this Plan.

H. DISCONTINUANCE OF COVERAGE OF RETIREES

The benefits of a Retiree shall cease automatically on the earliest of the following dates:

1. The end of the month for which the last full contribution has been made by the Retiree;

2. The date of death of the Retiree;

3. The date the Retiree becomes eligible for Medicare or coverage of any kind through State or Federal legislation;

4. The date of termination of this Plan.

I. DISCONTINUANCE OF COVERAGE FOR DEPENDENTS OF RETIREES

The benefits of a dependent of a Retiree covered under the Plan shall cease automatically on the earliest of the following dates:

1. The end of the month for which the last full contribution has been made by the Retiree for coverage with respect to dependents;

2. The date of death of the Retiree except as otherwise provided under the provision entitled "Coverage Extended to Dependents After Death of a Retiree";

3. The date the spouse becomes eligible for Medicare or coverage of any kind through State or Federal legislation;

4. The date a dependent child no longer meets the definition of a dependent as defined elsewhere in the Plan;

5. The date of termination of this Plan.

J. RECORD AND FILING OF CLAIMS

It is necessary to keep separate records of expenses with respect to each of the Employee's covered dependents as well as those of the Employee because the deductible and other provisions operate separately as to each covered individual.

A group health or dental claim form must be submitted for each covered Employee or dependent for whom a claim is made. Claims will not be accepted unless submitted to and received by the Claims Administrator prior to the end of the calendar year following the calendar year in which covered expenses have been incurred.

The following data are important and should be carefully kept to be submitted with each claim:

1. The name of thePhysician, surgeon orDentist.

2. The date each covered medical expense was incurred.

3. Copies of all statements, such as bills from Physicians, Hospitals and laboratories.

4. Physician's bills for office or house calls should show the date of the visit and charge made.

5. Each bill or statement should indicate clearly the name of the family member involved.

The Claims Administrator or HMO shall promptly review each claim form submitted and provide the participant with an explanation of the benefits payable under the Plan with respect to such claim. The participant shall then have the opportunity to discuss any questions with the Claims Administrator or HMO and provide the Claims Administrator or HMO with any additional information to enable the Claims Administrator or HMO to determine the correct amount of benefits payable.

K. RIGHT OF REIMBURSEMENT

In the event benefits are payable for charges incurred by a covered

Employee or dependent as a result of an accidental bodily injury or sickness sustained by such Employee or dependent,

1. the Employee shall reimburse the Employer to the extent of such benefit payments out of any recovery by the Employee or dependent (whether by settlement, judgment, or otherwise) from any person or organization responsible for causing such injury or sickness, or from their insurers, and the Employer shall have a lien upon any such recovery. In no event shall such reimbursement be in an amount exceeding the recovery made from the person or organization responsible for causing such injury or sickness, or made from their insurers.

2. the Employee or dependent shall execute and deliver such instruments and papers as may be required by the Claims Administrator and do whatever else is necessary to secure the rights of the Plan under (1) above.

The Employer shall be under no obligation under this Plan to recover such reimbursement for an Employee or dependent.

L. FRAUDULENT CLAIMS

It is the sole responsibility of the covered individual to complete the claim form answering all questions completely and truthfully to the best of his knowledge. Deliberate omissions or misrepresentations of fact, or falsification of a document or claim, or commission of any act that may result in overpayment of Plan benefits, shall result in recovery of overpayments and constitute sufficient cause for disciplinary action, including discharge. Retirees and the surviving spouses and dependents of Employees and Retirees may suffer loss of future coverage.

M. CLAIMS REVIEW AND APPEAL PROCEDURE

If a Plan participant is not satisfied with the handling of a claim by the Claims Administrator, the participant may file a formal written claim for benefits with the Human Resources Department. That Department shall either allow or deny the claim within 90 days, unless such period is extended for up to an additional 90 days at the discretion of the Department. Written notice of such extension shall be furnished to the participant prior to the expiration of the first 90-day period stating the special circumstances requiring the extension and the date by which a decision is expected.

A denial of a claim shall be written in a manner understandable to the participant and shall include the specific reasons for the denial, specific references to the pertinent Plan provisions, a description of any additional material or information needed to perfect the claim and an explanation of why the material or information is necessary, and an explanation of the claims appeal procedure.

If a claim is denied either in whole or in part, the participant may, within 60 days after receipt of the denial, submit a written request to the Committee for reconsideration, including a request for review of pertinent documents. Such request should be accompanied by whatever documents or records may be available to support the appeal. The participant will be advised of the Committee's decision, in writing, not later than 60 days after the request for review is received, unless such period is extended for up to an additional 60 days at the discretion of the Committee. Written notice of the extension shall be furnished to the participant prior to the expiration of the first 60-day period stating the special circumstances requiring the extension and the date by which a decision is expected.

Effective October 1, 2002, if a Plan participant is not satisfied with the handling of a claim by the Claims Administrator, the claimant or their authorized representative (claimant) may file a formal written claim for benefits with the **Human Resources Department**. The Department shall notify the claimant as follows:

1. **Urgent Care Claims**. If the claim is determined to require Urgent Care, the Department will notify the claimant of determination (whether adverse or not) no later than 72 hours after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Department shall notify the claimant, no later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The claimant shall have 48 hours to provide the specified information. The Department shall notify the claimant of the benefit determination 48 hours after the earlier of –

    a. The receipt of the specified information, or
    b. The end of the period afforded to the claimant to provide the specified additional information.

2. **Concurrent Care Decisions**. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

   a. Any reduction or termination by the Plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Department will notify the claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow an appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.
   b. Any request to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care shall be decided as soon as possible and the Department will notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

3. **Other Claims**. In the case of a claim not described above, the Department will notify the claimant of the Plan's benefit determination in accordance with the following –

   a. **Pre-Service Claims**. In the case of a Pre-Service Claim, the Department shall notify the claimant of the benefit determination (whether adverse or not) no later than 15 days after receipt of the claim. This period may be extended one time by the Department for up to 15 days, provided that the Department both determines that such an extension is necessary due to matters beyond its control and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which to expect a decision. If such an extension is necessary due to a failure by the claimant to submit the information necessary to decide the claim, the notice of

extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

In the case of a failure by the claimant to follow the Plan's procedures for filing a Pre-Service Claim, the claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided not later than 5 days (24 hours in the case of a failure to file a claim involving Urgent Care) following the failure. Notification may be oral, unless written notification is requested by the claimant.

b. **Post-Service Claims.** In the case of a Post-Service Claim, the Department will notify the claimant of the Plan's Adverse Benefit Determination no later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Department both determines that such an extension is necessary due to matters beyond its control and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which to expect a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Manner and content of notification of benefit determination -

1. Except as provided in paragraph 2 of this section, the Department will provide the claimant with written or electronic notification of any Adverse Benefit Determination. Any electronic notification shall comply with the standards imposed by the Department of Labor. The notification shall set forth the following information, in a manner calculated to be understood by the claimant –
   a. The specific reason or reasons for the adverse determination;
   b. Reference to the specific Plan provisions on which the determination is based;
   c. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
   d. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review;
   e. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or
   f. If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

g. In the case of an Adverse Benefit Determination concerning a claim involving Urgent Care, a description of the expedited review process applicable to such claims.

2. In the case of an Adverse Benefit Determination concerning a claim involving Urgent Care, the information described in paragraph 1 of this section may be provided orally within the time frame prescribed above, provided that a written or electronic notification in accordance with paragraph 1 of this section is furnished not later than 3 days after the oral notification.

If the claim has been denied by the Department, the claimant can appeal the denial in writing and have the claim reviewed by the Retirement and Benefit Plans Committee. The claimant has 180 days to appeal to the Committee from the time he is notified of the denial. Failure to appeal within such 180-day period will be deemed a failure to exhaust all administrative remedies under the Plan.

In the review of the appeal, the Committee must -

1. Provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

2. Provide that, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, there shall be consultations with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

3. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

4. Provide that the health care professional engaged for purposes of a consultation be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual; and

5. Provide, in the case of a claim involving Urgent Care, for an expedited review process pursuant to which—
   a. A request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the claimant; and
   b. All necessary information, including the Committee's benefit determination on review, shall be transmitted between the Committee and the claimant by telephone, facsimile, or other available similarly expeditious method.

Further, the Committee shall notify the claimant of the appeal determination on review in accordance with the following -

1. Urgent Care claims. If the treating Physician determines that the claim requires Urgent Care, the Committee shall notify the claimant of its benefit determination on review not later than 72 hours after receipt of the request for review of an Adverse Benefit Determination by the Department.
2. Pre-Service Claims. In the case of a Pre-Service Claim, the Committee shall notify the claimant of its benefit determination on

review not later than 30 days after receipt of the request for review of an Adverse Benefit Determination.

3. Post-Service Claims. In the case of a Post-Service Claim, the Committee shall notify the claimant of its benefit determination on review not later than 60 days after receipt of the request for review of an Adverse Benefit Determination.

Manner and content of notification of benefit determination on review - The Committee shall provide the claimant a written or electronic notification of the Plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by the Department of Labor. In the case of an Adverse Benefit Determination, the notification shall set forth the following information, in a manner calculated to be understood by the claimant -

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph 8 of this section;
4. A statement describing any voluntary appeal procedures offered by the Plan and the right to obtain the information about such procedures, and a statement of the right to bring an action under Section 502(a) of ERISA; and
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule,

guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

6. If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
7. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

8. "Relevant Documents" include documents, records or other information with respect to a claim that:

   a. were relied upon the Claims Administrator in making the benefit determination;
   b. were submitted to, considered by or generated for the Claims Administrator in the course of making the benefit determination, without regard to whether such documents, records or other information were relied upon by the Claims Administrator in making the benefit determination;
   c. demonstrate compliance with administrative processes and safeguards required in making the benefit determination; or
   d. constitute a statement of policy or guidance with respect to the Plan concerning the denied benefit for the person's diagnosis, without regard to whether such advice was relied upon by the Claims Administrator in making the benefit determination.

If an HMO participant is not satisfied with the handling of a claim, or if an HMO claim is denied either in whole or in part, the participant may submit a written request for reconsideration to the HMO in the manner outlined in the relevant

HMO Certificate or Subscriber Agreement received at the time of enrollment. Such request should be accompanied by whatever documents or records may be available to support the appeal. If the HMO participant is not satisfied with the response of this HMO claim review, the participant may submit a complaint through the individual HMO's grievance procedures. If the results of this review are not satisfactory to the HMO participant, an appeal of the decision may be directed to the Illinois Department of Insurance.

N. ACTION AT LAW OR EQUITY

No persons shall be entitled to challenge the determinations of the Claims Administrator, the HMO, the Human Resources Department, or the Committee in judicial or administrative proceedings without first complying with claims procedures set forth in the Plan. The determinations hereunder are intended to be final and binding on all persons.

No action at law or in equity shall be brought to recover on this Plan prior to the expiration of sixty days after proof of loss has been filed, nor shall such action be brought at all unless brought within three years and ninety days after the date of loss upon which the claim is based. If any time limitation of the Plan with respect to bringing an action at law or equity to recover on the Plan is less than permitted by the law of the State in which the covered person resides at the time the Plan is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

O. PLAN ADMINISTRATION

The Committee shall be the plan administrator and named fiduciary of the Plan. The Committee shall have all powers necessary to administer the Plan, including without limitation, to construe and interpret the Plan, to prescribe rules and procedures to be followed by Employees and dependents in applying for coverage and benefits, and to decide all questions of eligibility for benefits and the amount of benefits hereunder. Certain administrative duties are delegated to the Claims Administrator under various provisions of the Plan. The Committee may also delegate other specific duties to the Claims Administrator, to Employees of the Employer or to other individuals or entities.

P. PHYSICAL EXAMINATION

The Claims Administrator shall have the right and opportunity to examine a claimant when and so often as it may reasonably require during the pendency of a claim hereunder.

Q. WORKERS' COMPENSATION

This Plan is in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance.

R. PROVISIONS APPLICABLE TO HMO PARTICIPANTS

The provisions of this Plan, except those contained in Section IV-Medical Plan Benefits, shall also be applicable to Employees electing to participate in HMOs. HMO contract agreements will, however, supersede provisions of this Plan in any instance where there may be a conflict.

S. CONTINUATION OF PLAN

The Employer expects to continue this Plan indefinitely, but, except for specific requirements of collective bargaining agreements pertaining to this Plan and applicable to active employees, reserves the right, by action of its Board of Directors or duly authorized officers, to modify, amend or discontinue this Plan at any time.

If this Plan is modified, amended or discontinued, active Employees, Retirees or dependents may not receive the benefits described in the Plan or benefits may be provided only under different conditions. In no event will any individual become entitled to any vested right to the continuation of any benefits under this Plan.

The Employer also reserves the right to discontinue the Plan hereunder if participation in the Plan drops below 75%.

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Important Information

The following pages give you basic information about the Medical and Dental Plan. A complete description of the plan is included in the plan (legal) document. Should there be any disagreement between the description in your handbook and the legal document, the legal document will govern.

The plan is sponsored by Peoples Energy Corporation and its companies. For simplicity, the term "company" in this description means all the sponsoring companies as a group.

The Medical and Dental Plan is a welfare benefit plan that provides benefits to help pay the medical costs of nonoccupational illness and injury. The plan year is October 1 through September 30 for IRS purposes; however, you enroll in the plan for the calendar year, and your contributions and deductibles, etc. are on a calendar-year basis.

The company expects to continue the Medical and Dental Plan indefinitely, but reserves the right to change or terminate the plan.

This plan is subject to certain provisions of the Employee Retirement Income Security Act (ERISA).

Participants covered: Subscribing employees and retirees of sponsoring Peoples Energy companies and their eligible dependents.

If you communicate to the government about this plan, identify it with these numbers:

Employer I.D. number: 36-2642766
Plan number: 501

Summary

The Medical and Dental Plan features a preferred provider organization (PPO) option and a health maintenance organization (HMO) option to help with medical expenses if you or a family member has a non-work related illness or injury. The Medical and Dental Plan also features a traditional indemnity dental plan, which covers many dental expenses. (Whether you select the PPO or HMO option for your medical coverage, your dental benefits are provided through the dental portion of the Medical and Dental Plan.)

You pay contributions toward your coverage, but the company pays most of the cost.

While the focus of this section of your Benefits Handbook is on the Medical and Dental Plan's PPO option and dental benefits, the following topics *also* apply to the HMO option:

- Fraudulent Claims
- Coordination with Other Group Medical Plans
- When Medical and Dental Coverage Ends
- COBRA Continuation Coverage
- Dependent Coverage When You Die While Employed
- Medical Coverage After Retirement
- Administrative Information (see section 8: *Administrative Information*)

For more information on the HMO option, other than the topics listed above, see the section of this handbook titled, *Health Maintenance Organization*.

Medical Coverage

The Medical and Dental Plan generally pays 90 percent for in-network or 70 percent for out-of-network or combined in-network and out-of-network charges (union) or 80 percent for in-network or 60 percent for out-of-network or combined in-network and out-of-network charges (nonunion).

All in-network medical expenses, except those for mental health/substance abuse and prescription drugs, are paid based on a Schedule of Maximum Allowances determined by the Claims Administrator based on what the participating professional providers have agreed to accept as payment in full for a particular covered service.

All out-of-network expenses are paid based on reasonable and customary, or R&C, charges. An R&C charge is one that does not exceed the general level of charges made by doctors or other providers in a certain geographic area. If you choose out-of-network providers, the plan will not reimburse amounts considered to be more than the R&C amount.

The plan pays medical expenses due to illness and injury that are not related to work as follows:

- 100 percent in-network/70 percent out-of-network after deductible (union) or 100 percent in-network/60 percent out-of-network after deductible (nonunion) up to $250 per covered person per year for wellness benefits – certain health care costs related to routine screening and preventive services (no deductible requirement in-network)

- 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of hospital room and board and other hospitalization charges

- 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of doctors', surgeons', and many other medical charges including emergency treatment of an accidental injury, after payment of an annual deductible

- 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of charges for pre-admission and post-hospital testing, after payment of an annual deductible

- 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of outpatient surgery fees and operating room charges, after payment of an annual deductible

- 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of doctors' and surgeons' consulting fees for pre-hospital second surgical opinions (no deductible requirement)

- 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of charges incurred for dental care and treatment necessitated by accidental bodily injury to sound natural teeth, after payment of an annual deductible

- 100 percent in-network after $15 copay/50 percent out-of-network, no copay (union and nonunion) for out-patient physician charges in connection with diagnosis or treatment for mental health or substance abuse, including alcohol; subject to lifetime maximum provisions (no deductible requirement)

- 90 percent in-network/50 percent out-of-network (union) or 80 percent in-network/50 percent out-of-network (nonunion) of reasonable and customary charges in connection with inpatient, hospital room and board, and other hospital charges for treatment of mental health or substance abuse, including alcohol; subject to certain length of stay and lifetime maximum provisions (no deductible requirement)

- 90 percent (union) or 80 percent (nonunion) reimbursement for vision care (up to $200 per covered person per year), including routine eye exams, glasses and contact lenses

Union:

- 80 percent for each of the first two retail prescription drug fills (but not less than $25 for brand name, $10 for formulary, $5 for generic); 70 percent for third and subsequent retail prescription fills (but not less than $50 for brand name, $20 for formulary, $10 for generic); $30 copay (brand name),

$15 copay (formulary), $10 copay (generic) for mail service prescription drugs (no deductible requirement)

Nonunion:

- 80 percent for each of the first two retail prescription drug fills (but not less than $30 for brand name, $20 for formulary, $10 for generic); 70 percent for third and subsequent retail prescription fills (but not less than $60 for brand name, $40 for formulary, $20 for generic); $30 copay (brand name), $20 copay (formulary), $10 copay (generic) for mail service prescription drugs (no deductible requirement)

- There are annual, calendar-year deductibles for an individual and for a family. See *Medical and Dental Plan Details* in this section for more information.

- The plan will pay 100 percent of covered medical charges described here once your coinsured covered medical expenses in excess of the deductibles reach the following amounts during the calendar year:

  - For the family as a whole: $2,500 in-network ($4,500 combined in network and out-of-network charges), or

  - For an individual family member: $1,500 in-network ($3,000 combined in-network and out-of-network charges)

The plan covers the expenses shown above up to a lifetime maximum of $1 million per person, including the treatment of mental health and substance abuse, including alcohol.

Dental Coverage

Dental coverage is provided through a traditional indemnity dental plan if you are enrolled in the Medical and Dental Plan, whether you choose the PPO or the HMO option. The plan pays reasonable and customary charges for certain dental expenses as follows:

- 90 percent of covered charges for preventive care (no deductible requirement)

- 80 percent of covered charges for basic care after meeting a separate annual $50 per person or $150 per family deductible

- 50 percent of covered charges for major care also subject to the deductible

- 50 percent of covered charges for orthodontia for dependent children under age 19 (no deductible requirement)

The maximum annual reimbursement for covered basic, preventive and major services is $1,750 per person. Orthodontic work has a separate lifetime maximum of $2,000 per person

Paying for Medical and Dental Coverage

The company funds trusts to provide for payment of medical and dental benefits for active and retired participants covered under the plan. The cost of the plan is shared between you and the company, with the company paying the major portion.

The company funds union and nonunion trusts to provide for the payment of medical and dental benefits for active and retired participants covered under the plan. Claims Administrators — BlueCross BlueShield of Illinois (administrator of the PPO medical option as well as provider of dental benefits through PreDent), Caremark (prescription drugs) and United Behavioral Health (mental health and substance abuse) — were hired to process claims and assure that benefits are paid properly. Funding amounts recognize future claim costs and other applicable considerations. The Claims Administrators do not guarantee or insure any of the benefits. Company and employee contributions are deposited in the plan's trust funds — The Peoples Energy Corporation Life and Health Benefits Trust for Bargaining Unit Employees and Retirees and The Peoples Energy Corporation Life and Health Benefits Trust for Nonbargaining Unit Employees and Retirees. The funds are managed for the exclusive benefit of plan participants. The trustee of the funds is The Northern Trust Company, Chicago, Illinois.

Medical and Dental Participant Contributions

A participant makes two kinds of monthly contributions, one for the medical portion of the plan and one for the dental portion of the plan.

Your medical and dental coverage contributions are deducted from your paycheck. The amount of your contributions depends on whether you choose employee or retiree only or another level of coverage. Contribution amounts are issued annually during open enrollment. You will be advised whenever a change in costs affects your contributions.

Pre-Tax Payment Opportunity

For active employees, premium contributions can be paid on a pre-tax or after-tax basis. Under the pre-tax contribution program, your monthly premium contributions are deducted from your regular pay before federal, state, and Social Security taxes are taken — the result is that taxes are reduced, and take-home pay is correspondingly increased. By law, the pre-tax contribution is available only to active employees. Employees on layoff status and retirees are not eligible to participate. The opportunity to enroll in the pre-tax contribution program is limited to once a year and, generally, your participation remains in effect for the entire year. New employees can enroll in the program at the time they are hired.

Medical and Dental Plan Details

The medical portion of the company's Medical and Dental Plan includes two options: a preferred provider organization (PPO) or a health maintenance organization (HMO). For more about the HMO option, see the *Health Maintenance Organization* section of this handbook.

A PPO provides medical services at wholesale costs through contracts with a network of doctors and hospitals. Each time you seek medical services, you have the option of choosing any doctor or hospital within or outside of the network. However, you realize larger cost savings if you utilize the in-network, contracted providers.

In-network means medical service rendered by a health care provider who is affiliated with the BlueCross BlueShield of Illinois PPO under the Medical and Dental Plan to provide health care to employees, retirees and eligible dependents. Out-of-network means medical service received from health care providers not affiliated with the BlueCross BlueShield of Illinois PPO under the Medical and Dental Plan.

Check the network directory available from Human Resources Service Center at 1-866-YOURHR3 (968-7473), or call BlueCross BlueShield for the most up-to-date list of participating providers. The number is 1-800-837-3152. Or go online to www.bcbsil.com.

Dental coverage is provided through the Medical and Dental Plan if you are enrolled in the Medical and Dental Plan or an HMO (health maintenance organization.) The plan — which is a traditional indemnity plan — pays for preventive dental care, a wide variety of basic and major dental services, and orthodontia services for dependent children under age 19. Unlike the medical portion of the Medical and Dental Plan, there are *no* in-network or out-of-network considerations for dental benefits.

Medical Coverage

The plan covers most *medically necessary* charges for illness and injury — provided the illness or injury is not job related. To be defined as medically necessary, the treatment must be legal, not experimental, and ordered by a physician as part of a safe and effective course of treatment that is generally accepted by the American medical community. Custodial care or redundant or preventive treatment *will not* be considered medically necessary.

The plan generally pays 90 percent (union) or 80 percent (nonunion) of in-network charges (subject to the Schedule of Maximum Allowances determined by the Claims Administrator) and 70 percent (union) or 60 percent (nonunion) of out-of-network charges. The Schedule of Maximum Allowances represents discounted amounts for services negotiated by BlueCross BlueShield with

All in-network medical expenses, *except* those for mental health/substance abuse and prescription drugs, are subject to the Schedule of Maximum Allowances. All out-of-network expenses are paid based on *reasonable and customary*, or R&C, charges.

When Medical Benefits Begin

Benefits for most expenses begin after satisfaction of a deductible requirement.

The Medical Deductible

There are deductibles for an individual and for a family. Benefits begin each calendar year after you pay the specified amount of the medical expenses to which the deductible applies. In other words, a deductible is the amount you must pay, out of your pocket, for covered services before the plan pays any benefits. The deductibles are:

In-Network (union & A&T)	Out-of-Network (union & A&T)
$200 per person, per year	$400 per person, per year
$400 per family, per year	$800 per family, per year
In-Network (management)	**Out-of-Network (management)**
$250 per person, per year	$500 per person, per year
$500 per family, per year	$1,000 per family, per year
In-Network (officers)	**Out-of-Network (officers)**
$400 per person, per year	$500 per person, per year
$800 per family, per year	$1,000 per family, per year

For families, once the deductible expenses of two or more covered family members total the in-network or out-of-network, all covered family members may begin receiving benefits.

For example, for a union or A&T employee, his or her family's in-network deductible is satisfied if two family members each have $200 of eligible deductible expenses, or if four family members each have $100 of eligible deductible expenses.

If you incur medical expenses both in-network and out-of-network, the higher out-of-network deductible will apply. The in-network deductible goes toward meeting the out-of-network deductible.

The Plan allows a three-month carryover deductible. This means expenses that occur in October, November and December that are applicable to the deductible also count toward satisfaction of the deductible in the following calendar year.

Medical Annual Out-of-Pocket Expense Maximum

Under certain circumstances, a family's medical expenses covered at the 70 percent union/60 percent nonunion (combined in- and out-of-network) or 90 percent union/80 percent nonunion (in-network) rate may cause them to incur out-of-pocket expenses, in excess of the deductibles, that reach the plan's out-of-pocket expense maximums. These maximum amounts are as follows:

In-network	Out-of-network*
$1,500 per person, per year	$3,000 per person, per year
$2,500 per family, per year	$4,500 per family, per year

*Out-of-pocket expenses for in-network and out-of-network charges can be combined toward reaching the out-of-network maximums.

Once the out-of-pocket expense maximums are met, the plan may pay 100 percent of any additional covered charges for that individual or family for the rest of the year — up to the lifetime maximum benefit.

Out-of-pocket expenses related to dental care or those used to satisfy the deductibles and penalties imposed under the Managed Health Services Program (see *Managed Health Services Program* in this section for details) do not count toward the out-of-pocket annual maximums.

Here is an example for a management employee of how a family member's medical expenses could be covered, in-network, under the plan:

	Covered Expenses	Deductible	Plan Pays	You Pay
Hospital charges	$10,000	—	$8,000	$2,000
Doctors' fees	500	$250	250	250
Total	$10,500	$250	$8,250	$2,250

Under this example, the family member incurred a total of $10,500 in-network medical expenses. Because the individual reached the level of $1,500 in out-of-pocket expenses in excess of the deductible for one individual, the plan would then pay future eligible medical expenses incurred by this individual at 100 percent.

If other family members meet the remaining $250 portion of the $500 family deductible, and also incur an additional $250 in covered medical expenses, their subsequent eligible expenses for the calendar year would be reimbursed at 100 percent. This is because the family will have met the in-network deductibles as well as the annual out-of-pocket maximum of $2,500.

Medical Lifetime Maximum Benefits

The plan pays certain covered medical charges — including prescription charges and charges for inpatient and/or outpatient treatment for mental health and/or substance abuse, including alcohol — up to a lifetime maximum of $1 million per person. When the individual maximum has been reached, coverage for medical expenses under the PPO portion of the Medical and Dental Plan ends.

Medical Coverage of and Treatment for Bodily Injury, Illness or Pregnancy

The plan generally pays a major portion of the medical expense for care of bodily injury and illness and for pregnancy. Hospital charges and doctors' fees for inpatient and for outpatient care are included. A Schedule of Maximum Allowances is set on these charges and fees by the Claims Administrator based on what the participating professional providers have agreed to accept as payment in full for a particular covered service. All in-network medical expenses, except those for mental health/substance abuse and prescription drugs, are subject to the Schedule of Maximum Allowances. All out-of-network medical expenses are paid subject to reasonable and customary charges.

Following are two lists that show the kind of hospital charges and doctors' fees typically covered by the plan. One list is for outpatient services and the other is for inpatient care. Each list shows the percentage of expense covered, and whether or not there is a deductible. Check with your Claims Administrator representative for more precise information.

The plan generally pays 90 percent (union) or 80 percent (nonunion) for in-network or 70 percent (union) or 60 percent (nonunion) for combined in-network and out-of-network charges after the deductible of the following inpatient and outpatient expenses and fees subject to the provisions of the Managed Health Services Program (see *Managed Health Services Program* in this section for details):

Inpatient

- Surgery fees
- Visits by your physicians
- Consulting specialists
- Obstetrical services (delivery)
- Surgical implants
- Hemodialysis
- Open heart surgery
- Medical treatments given by a qualified doctor
- Room and board
- Private duty registered nurses ordered by your doctor
- Hospital charges for: operating, recovery, delivery and nursery room, x-ray treatments; radioisotopes; oxygen; laboratory services; x-rays; fluoroscopy, EKG; EEG dressings; anesthesia; intravenous fluids; blood and the cost of the administration of blood
- Physical, occupational and speech therapies

The plan may pay 100 percent of covered medical charges described here, if your out-of-pocket expenses in excess of the deductibles reach the annual maximum for the family as a whole or for an individual family member during the calendar year. (See *Medical and Dental Plan Details* in this section for more information.)

Also, note that under the Managed Health Services Program, described in this section, hospital stays will be reviewed to ensure that they are no longer than necessary.

Outpatient

- Visits to your physician's office
- Visits to consulting specialists
- Physician fees for outpatient surgery
- Outpatient operating room charges and related expenses
- Diagnostic services: x-rays; fluoroscopy; EKG; EEG; clinical isotope services; laboratory tests
- Pre-hospital testing (when performed up to 72 hours before admission)
- Post-hospital testing (when performed up to seven days after hospitalization ends)
- Anesthesia
- Oxygen
- Physical, occupational and speech therapies (subject to $1,000 maximum limit per therapy per calendar year)
- Rental of an iron lung
- Rental of oxygen tent, hospital bed, wheel chair, or similar medical equipment
- Artificial eyes and limbs (one time only)
- Private duty nursing when ordered by your doctor (subject to $1,000 maximum limit per person per month)
- Presurgical second opinions
- Mammography screening, as determined by the following schedule:

Age of Insured	Frequency of Mammogram
35 - 39	Baseline mammogram
40 - 49	Every two years
50 or older	Annually

The plan may pay 100 percent of covered medical charges described here, if your out-of-pocket expenses in excess of the deductibles reach the annual maximum for the family as a whole or for an individual family member during the calendar year. (See *Medical and Dental Plan Details* in this section for more information.)

Keep in mind that the amount charged in-network by a hospital or doctor will be determined based on the Schedule of Maximum Allowances. Only that much will be covered. Out-of-network charges will be based on reasonable and customary charges.

Other expenses and fees

Pregnancy is covered in the same way as any other illness or injury. Related services are listed here. Additional information is presented under *Pregnancy*, later in this section.

There are maximum lifetime limits on payment for the inpatient and outpatient treatment of mental health and substance abuse, including alcohol. Therefore, such treatment is not listed here. Instead, it is discussed under the *Mental Health and Substance Abuse, Including Alcohol* section.

The plan covers some specialized kinds of health care facilities and services. These are discussed separately under the sections *Extended Care*, *Home Health Care* and *Hospice Care*.

Prescription Drug Program

The Prescription Drug Program is designed to provide you and your family a convenient and cost-effective way to obtain prescription medication for short-term or long-term needs. The program is administered by Caremark, the Plan's prescription drug Claims Administrator.

The program gives you two options through which to purchase medically appropriate prescription drugs at a discounted price:

- A participating Caremark retail pharmacy, or
- Caremark's Mail Service Program.

If you have any questions, you can call Caremark at 1-800-824-6349 or the Human Resources Service Center at 1-866-YOURHR3 (968-7473). You can also register online with Caremark at www.caremark.com, using the information on your Caremark Prescription Drug Card, to take advantage of their online services. The online services allow you to:

- Order refills
- Verify order status
- Check benefit coverage
- Research drug information
- View prescription history
- Locate retail pharmacies
- Access health information

There are three types of prescription drugs that your physician may prescribe:

- Brand-name — A drug that is approved by the Food and Drug Administration (FDA), and is supplied by one company (the pharmaceutical manufacturer). The drug is protected by a patent and is marketed under the manufacturer's brand name.

- Formulary — A drug from a list of the highest quality, most cost-effective drugs that a health plan maintains as a guide for physicians. Caremark will send you a brochure that includes a listing of their formulary drugs.
- Generic — After a brand-name drug's patent expires, other companies may produce *generic* forms of the drug. A generic drug is therapeutically and chemically equivalent to the brand name drug and, by law, must meet the same standards for safety, purity, strength and quality.

Retail Program

You generally use the Retail Program for short-term prescription drugs. When you use the Retail Program, you are limited to a 30-day supply of your medication. (The number of refills is subject to your doctor's authorization.) After you fill your prescription twice through the Retail Program, you can continue to use the Retail Program and pay a higher percentage, or you can use the Mail Service Program and pay a flat fee (see chart below). Although use of the mail service feature is not required, the company encourages you to make use of it whenever possible, given its convenience, security and cost savings to both the participant and the company.

Mail Service Program

You can use the Mail Service Program for maintenance and long-term medications. Maintenance drugs or long-term prescriptions are drugs prescribed for more than 30 days, or drugs taken on a regular or long-term basis, e.g., drugs for high blood pressure, arthritis, heart conditions and diabetes. When you use the Mail Service Program, you receive up to a 90-day supply of your medication. (The number of refills is subject to your doctor's authorization.) Although use of the mail service feature is not required, the company encourages you to make use of it whenever possible, given its convenience, security and cost savings to both the participant and the company.

To receive your prescription, mail your original prescription and your Patient Profile/Order Form to Caremark, P.O. Box 7624, Mount Prospect, IL 60056-7624 or, P.O. Box 407009, Ft. Lauderdale, FL 33340-7009. Your medication will be sent directly to your home. You can order refills and check the status of your order online at www.caremark.com when you register for their online pharmacy services. Or you can call Caremark's phone service at 1-800-213-0879. This process can take several weeks, so make sure to plan accordingly.

Costs Through the Prescription Drug Program

	Retail Program (30-day supply)				Mail Service Program (90-day supply)	
	First two fills		*Third and subsequent fills*			
You Pay	Greater of 20% or...		Greater of 30% or...		Flat fee...	
	Union	Non-union	Union	Non-union	Union	Non-union
Generic	$5	$10	$10	$20	$10	$10
Formulary (primary drug list)	$10	$20	$20	$40	$15	$20
Brand Name (not on the formulary list)	$25	$30	$50	$60	$30	$30

Once a participant has paid $1,000 out of pocket in a calendar year, any remaining prescriptions will be reimbursed at 100% for the remainder of the calendar year.

Managed Health Services Program

The Managed Health Services Program is designed to assist you and your family by evaluating the medical necessity of admission to a hospital.

The program is administered by specially qualified registered nurses and Medical Advisors who work with BlueCross BlueShield's Medical Service Advisory Review Unit for the following hospital admissions:

- Pre-Admission Review for all *elective* and *maternity* hospital stays
- Admission Review for all *emergency* hospital stays
- Continued Stay Review and Discharge Planning for *all hospital stays*

As partners in the effort to maximize our medical benefits, the company and plan participants each have certain responsibilities. Therefore, to assure that you receive the maximum benefit available to you, you must follow the procedures described.

If you fail to follow the procedures described here, your benefit payment will be reduced. Failure to notify the Medical Service Advisory Review Unit in a timely manner for any elective or emergency admission or failure to comply with review recommendations will result in a separate $400 facility charge, per admission. This amount will not be applied to your deductible or any out-of-pocket maximum.

Elective Admissions — Nonmaternity

Before you or one of your covered dependents schedules nonemergency, inpatient hospitalization, you or your physician (or someone from your physician's office) must notify BlueCross BlueShield of Illinois' Medical Service Advisory Review Unit in advance of the confinement at 1-800-572-3089. Their office hours are Monday through Friday, 7am - 6pm, Central Time. However, there is an answering service after office hours. If it is more convenient, you and your physician can complete and send a hospital Pre-Admission Form to the Unit at least 10 days prior to admission.

The Medical Service Advisory Review Unit's professionals will obtain specific information from your physician, noting specific reasons for your proposed hospitalization and length of stay, and will ensure that the proposed hospitalization meets the requirements of the plan. This review is based on your needs as a patient, physician-developed criteria, and regional hospital patient admission studies.

Upon receipt of full information, the review will be completed, generally within one working day. Written confirmation of the results will be provided to you, your physician, and your hospital. If time is pressing, you and your physician will be contacted by telephone, followed by the usual written confirmation. The Medical Service Advisory Review Unit's staff may recommend to your physician that your treatment be administered in an outpatient setting or that testing be done prior to admission.

Elective Admissions — Maternity

Maternity and related admissions are not entirely unexpected. Therefore, you must notify the Medical Service Advisory Review Unit prior to the time you expect to enter the hospital. You actually may have a scheduled date, if you and your physician have agreed on an elective cesarean section. In all cases, if the date that you or your dependent is actually admitted for maternity reasons is not firmly scheduled, and you have not given notice of the exact date, you, your physician, your family, or someone at the hospital must contact the Medical Service Advisory Review Unit within 48 hours of admission (72 hours if the confinement begins on a Saturday, Sunday, or legal holiday).

Emergency Admissions

Of course, in an emergency, no one expects you to call before you go into the hospital. Your health and well-being come first, and you should get whatever care your physician recommends. However, you, a family member involved in your health care, your physician, or someone at the hospital must call the Medical Service Advisory Review Unit at 1-800-572-3089 as soon as possible within 48 hours of admission (72 hours if the confinement begins on a Saturday, Sunday, or legal holiday). Their office hours are Monday through

Friday, 7am - 6pm, Central Time. However, there is an answering service after office hours. Once you are hospitalized, your case is reviewed like any other hospitalization under the Pre-Admission Review process.

Continued Stay Review

During your hospital stay, the Medical Service Advisory Review Unit's staff will contact your physician at regular intervals to see if you are remaining in the hospital the expected length of time. If your physician decides that you need to stay in the hospital longer, the request for extension will be reviewed, based on the new information your physician will provide.

If the request for extension is approved, your doctor will be notified by phone. If your physician has not provided satisfactory additional proof of medical appropriateness to support the request for extension, your doctor will be called, and written confirmation will be sent to your physician and your home.

Discharge Planning

Often there are alternatives to an extended hospital stay, and the plan provides coverage for many of these, including hospice, home health care, and extended care facilities. A Medical Service Advisory Review Unit professional will discuss appropriate options with your doctor so that, together, you and your physician can decide what is best for you.

If, in the course of Continued Stay Review or Discharge Planning, you decide to remain in the hospital beyond the number of days deemed reasonably necessary, payment for additional hospital days will be made only if your physician provides satisfactory additional proof of medical necessity.

Requesting Reconsideration from Managed Health Services

Normally, differences of opinion will be easily resolved between your physician and the Medical Advisor who initially reviews your case. However, if at any time in the review process you or your physician disagrees with the result of the review regarding the medical appropriateness of admission or length of stay, reconsideration of the review decision may be requested. Reconsideration is initiated by you or your physician calling or writing to BlueCross BlueShield, the Claims Administrator. This request should be made in a reasonably prompt manner for timely reconsideration to be given.

If the Claims Administrator denies reconsideration, a written appeal may be made to the company as outlined in section 8: *Administrative Information*.

Medical Case Management

When you or your dependent suffers from a long-term or serious illness or injury, this program may be made available to help you explore alternate medical care choices that can offer more efficient use of benefits under the Plan.

In addition to the Managed Health Services Program, the plan offers a special program called Medical Case Management. The types of illnesses and injuries that may be considered appropriate for Medical Case Management include high risk newborns, severe stroke, certain cancers, serious burns or fractures, head injuries, AIDS, multiple sclerosis, and other grave diagnoses.

In the event that you or your dependent suffers from a long-term or serious illness or injury, this program may be made available to help you explore alternate medical care choices that may offer more efficient use of benefits under the plan. In some cases, the Case Management Consultant may offer an option that is an authorized exception to plan provisions. These alternatives will be reviewed with you and your physician. You have the right to accept or reject the proposed alternative course of treatment recommended by the Consultant. In no event, however, will the plan pay benefits for inpatient confinement deemed not medically appropriate through normal hospitalization review by the Managed Health Services Program.

Please remember that appropriate coinsurance percentages and deductibles will be applied in determining benefits. Benefits paid under Medical Case Management are included within and are not in addition to overall individual and family lifetime maximums.

Peoples Energy Corporation, through Medical Case Management and the Managed Health Services program is committed to helping you find the most appropriate care possible.

Wellness Benefits

The plan pays up to $250 for wellness benefits per covered person per year. When you use in-network providers, you do not have to satisfy your deductible before the plan pays benefits. If you use out-of-network providers, your benefits are subject to your deductible and coinsurance. In either case, you must pay costs more than the $250 benefit limit.

Covered services include:

- Office visits for routine physical examinations
- Immunizations (travel-related immunizations not included)
- Routine gynecological examinations
- Routine Pap smears

- Routine PSA tests
- Routine labs, x-rays, and blood tests
- Well-child care for children under age six

Pregnancy

The medical plan covers pregnancy and childbirth in the same way as an illness or injury. A newborn must be enrolled within 60 days of birth.

Employees and covered dependents are eligible for pregnancy benefits under the medical plan.

The plan covers the medical costs of pregnancy and childbirth (or other termination of pregnancy) in the same way it covers illness and injury.

All hospital inpatient confinements are subject to maternity Pre-Admission Review, Maternity Admission Notification, Continued Stay Review, and Discharge Planning provisions of the Managed Health Services Program.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The employee's new child may also be covered by the plan beginning on his or her date of birth. To secure coverage the employee must notify the company of the birth within 60 days of the birth and complete Form 1414 (Medical Dependent Declaration Section), returning the signed form to Human Resources and subsequently furnishing a birth certificate at the earliest time. *You must notify the company of your new family member whether or not you need to change your class of coverage.* See *Eligibility and Participation* in the *Overview of Health Care Benefits* section for more information about dependent coverage.

Ambulance and Blood Services

The plan pays 80 percent of charges for ambulance service and for the cost of blood, under certain circumstances.

Ambulance

The plan pays 80 percent (in-network and out-of-network) of the cost of professional ambulance service — ground or air transportation — to transport a sick or injured person to and from the hospital after the annual deductible requirement is met.

Blood

The plan pays 80 percent of charges for blood or blood plasmas and for the administration of blood, under certain circumstances.

Note: Company employees and all annuitants receive blood free of cost through the Life Source-sponsored Blood Replacement Program, which is made possible through regular blood donations by employees. Blood administration expenses are covered by the plan, as stated above.

Home Health Care

If certain care usually given in a hospital is given at home by a qualified agency under an approved plan, the plan pays 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of the cost of this care — after the in-network annual deductible requirement is met.

In certain limited circumstances, treatment that is normally given in a hospital — for example, certain kinds of therapy and some convalescent care — can be administered at home. The plan covers this care, called "home health care," if it meets these three conditions:

- Care is given by a qualified home health care service or by a hospital authorized to give home health care services,
- Care is administered under a predetermined plan approved by the patient's doctor, and
- The doctor certifies that in the absence of a home health care program, the patient would have to be hospitalized.

If these conditions are met and the annual in-network deductible requirement has been satisfied, the plan pays 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion).

Covered Charges:

- Part-time nursing care under the supervision of a registered nurse;
- Personal care given by the home health care service;
- Physical, occupational, and speech therapy (subject to $1,000 maximum limit per each therapy per year); and
- Medical supplies, drugs, medicine and laboratory services that would have been covered had the patient been hospitalized, if they are ordered by a doctor.

Home health care benefits will not be paid for transportation services, costs that are eligible for Medicare, or custodial care (that is, care primarily for a person's physical needs).

Contact BlueCross BlueShield's Medical Service Advisory Review Unit for more detailed information before arranging home health care.

Extended Care

Coverage is provided for skilled nursing care at an extended care facility following a hospital stay. Certain conditions apply.

When skilled nursing care is required following treatment at a hospital, an "extended care facility" may be able to provide it at the most reasonable cost. The plan covers such charges if these conditions are met:

- Confinement must be in a qualified extended care facility that is not primarily engaged in providing custodial care,
- Confinement must begin by means of a direct transfer from a hospital in which the individual was confined for at least three days, and
- Confinement must be for the same condition that caused the individual to be hospitalized.

Charges for the use of an extended care facility are paid by the plan at 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) after the deductible. Following is a list of the kind of services that are covered:

- Room and board (limited to 60 days per person per year)
- Nursing care (except private duty), up to $1,000 per person, per month (nonunion)

- Physical, occupational, and speech therapies (subject to $1,000 maximum limit per therapy per year) (nonunion)
- Medical social services under the direction of a physician
- Biologicals, supplies, appliances, and equipment
- Diagnostic and therapeutic services
- Other necessary services generally provided to patients by extended care facilities

Contact BlueCross BlueShield's Medical Service Advisory Review Unit for more detailed information before arranging a stay at an extended care facility.

Hospice Care

Hospice care is specialized care for patients known to be terminally ill. This kind of care will be covered for a six-month period, when a physician certifies that a patient is terminally ill. The benefit may be extended for further periods once the doctor certifies the condition continues.

Inpatient Hospice Care

Inpatient care at a hospice or arranged for by a hospice will be paid at 90 percent in-network/80 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) after deductible. This can include one period of "respite care" per calendar month, where an individual who has been receiving *hospice home care* goes to the *Hospice*, to give family members a break from the strain of providing health care to a terminally ill loved one. Confinements for custodial care will not be covered under the plan. Contact your Claims Administrator claims approver for more detailed information before arranging for Hospice care.

Hospice Home Care Services

This plan will cover services and supplies used in the patient's home, if they are provided or arranged for by a hospice as part of a written hospice care plan. Coverage is at 90 percent in-network/80 percent out-of network (union) or 80 percent in-network/60 percent out-of-network (nonunion) after deductible, and there is a lifetime maximum of $12,500. Following is a list of the kinds of services and supplies covered.

- A doctor's care
- Part-time nursing care

- Physical, respiratory, occupational, and speech therapies (subject to $1,000 maximum limit per therapy per year) (nonunion)
- Counseling by a registered dietician
- Part-time services of a trained home health aide
- Laboratory services, drugs, medication, medical supplies, and appliances prescribed by a physician
- Transportation of the patient to the place where hospice home care will be received

Vision Care

The plan pays 90 percent (union) and 80 percent (nonunion) per person per year — up to $200 — for the costs of routine eye exams, glasses and contact lenses. There is no deductible for vision care benefits. You can visit the vision care provider of your choice.

To receive benefits, you or your provider must file a claim with BlueCross BlueShield. If you submit the claim, you will be reimbursed for your costs, up to the $200 maximum (use the standard claim form available from BlueCross BlueShield at www.bcbsil.com or by calling 1-800-837-3152).

Mental Health and Substance Abuse, Including Alcohol

The plan generally pays a major portion of the medical expense for treatment of mental health and substance abuse, including alcohol. Hospital charges and doctor's fees for inpatient and for outpatient care are included. However, strict limits are set on the number of days that will be covered.

United Behavioral Health (UBH) is the Claims Administrator for treatment of mental health and substance abuse, including alcohol. You may call UBH at 1-800-888-2998 for a referral to an in-network provider in your area.

Inpatient Care

The plan pays in-network charges at 90 percent (union) and 80 percent (nonunion) (50 percent out-of-network), with no deductible, for the treatment of mental health and substance abuse, including alcohol. There is a $1,000 out-of-pocket maximum per person per calendar year. Benefits are payable for no more than 30 days of confinement in a calendar year for each covered

person, except for treatment of substance abuse, which is limited to only a second confinement in a lifetime after at least 5 years have passed after the first confinement.

Outpatient Care

In-network physician charges for outpatient treatment of mental health and substance abuse, including alcohol, are covered at 100 percent of reasonable and customary charges subject to a $15 copay per visit. Out-of-network treatment is covered at 50 percent of reasonable and customary charges. There is a limit of 30 visits in a calendar year for each covered person.

Lifetime Maximum Benefits

For each individual, benefits paid for treatment of mental health and substance abuse, including alcohol, are included in the overall individual lifetime maximum, subject only to a 60-day inpatient lifetime maximum for each covered person.

Psychiatric and Substance Abuse Case Review

Psychiatric and Substance Abuse Case Review is provided by United Behavioral Health. UBH is the administrator of the mental health and substance abuse benefits provided under the Medical and Dental Plan. The purpose of Psychiatric and Substance Abuse Case Review is to help you make the most of your benefits for inpatient treatment of mental health and substance abuse, including alcohol. Related cases are reviewed by a Psychiatric and Substance Abuse Case Review Specialist.

Hospital confinements for mental health and substance abuse, including alcohol, are subject to all elements of the Managed Health Services Program review process, including penalties for noncompliance described under that section. This means that, in all cases, medical appropriateness must be effectively demonstrated for inpatient confinement to make certain that you or your dependent receives the maximum level of benefits for which you are eligible under the plan.

If you or a dependent is hospitalized for treatment of mental health and/or substance abuse, including alcohol, notify United Behavioral Health's Intake Counselor. You and your physician should make certain that UBH is called at their toll free number 1-800-888-2998. Intake counselors are available 24 hours, seven days a week.

A Psychiatric and Substance Abuse Case Review Specialist will review the case for necessity of admission and appropriate length of stay. During the course of confinement, the Specialist may recommend alternative medical care choices that offer more efficient use of benefits provided under the plan. In some cases, these alternatives may involve authorized exceptions to plan provisions. These will be reviewed with you and your physician. You have the right to accept or reject the proposed alternate course of treatment recommended by the Specialist. In no event, however, will the plan pay benefits for inpatient confinement deemed not medically appropriate through normal hospitalization review by the Specialist.

Benefits paid under Psychiatric and Substance Abuse Case Review are included in the lifetime maximum benefit for mental health and substance abuse available as part of the overall individual lifetime maximum.

Medical Coverage Exclusions

The Medical and Dental Plan does not cover the following:

- Charges for medical services and supplies that are in excess of the Schedule of Maximum Allowances established by BlueCross BlueShield of Illinois or that are in excess of reasonable and customary charges (See *Medical and Dental Plan Details* in this section for an explanation of the Schedule of Maximum Allowances.)
- Charges for medical services and supplies that are not medically necessary (except for mammogram screening, vision and wellness benefits)
- Charges not considered appropriate under the administrative practices commonly adhered to by the Claims Administrators
- Illness or injury that is related to work
- Treatment or hospitalization that is not approved by a qualified doctor
- Cosmetic surgery unless it is made necessary by accidental injury that occurs while you are insured
- Dental treatment other than the treatment for accidental bodily injury to sound natural teeth
- Hearing aids — or the examination to prescribe them
- Care that is primarily custodial in nature, such as extended care or nursing home care

- Illness or injury caused by war, by self-inflicted injury, or by participation in a riot or commission of a felony
- Services provided by any medical practitioner who is related to the patient or lives in the patient's household
- Medical services or supplies that are furnished or paid for by the government or provided through government programs, or for which the patient is under no legal obligation to pay

Note: The above is a partial list of exclusions; others may apply.

Dental Coverage

Dental coverage is provided through the Medical and Dental Plan if you are enrolled in the PPO option or an HMO.

BlueCross BlueShield of Illinois is the Claims Administrator for the dental plan; benefits are provided through PreDent.

The plan — which is a traditional indemnity plan — pays for preventive dental care, a wide variety of basic and major dental services, and orthodontia services for dependent children under age 19.

Unlike the medical portion of the Medical and Dental Plan, there are no in-network or out-of-network considerations for dental benefits.

The plan pays 90 percent of covered charges, without deductible, for preventive care services. After satisfaction of a $50 per person, or $150 per family per year deductible, the plan also pays 80 percent of covered charges for basic care services and 50 percent for major care services. Finally, the plan pays for 50 percent of covered charges, without deductible, for orthodontia services provided to dependent children under age 19.
Just as with the medical deductible, dental expenses that occur in October, November, and December — and are applicable to the deductible — also count toward satisfaction of the dental deductible in the following calendar year.

The plan will reimburse no more than $1,750 of dental care expenses for any covered individual in a given year. That limit applies to preventive care, basic care, and major care services, combined. Reimbursements for orthodontic work for any covered child have a *separate lifetime maximum* of $2,000.

For a complete list of items covered by the plan see *Covered Dental Procedures* in this section.

In the event dental charges are expected to exceed $250, the plan provides a pre-treatment review feature to assist you in determining your benefit coverage

before services are rendered. (See *Other Dental Coverage Provisions* in this section for a complete explanation of pre-treatment review and its related provisions.)

Other Dental Coverage Provisions

The plan contains additional features to assist you in determining your benefit coverage and to provide cost-effective treatment.

Pre-treatment estimate

In the event charges for dental services are expected to exceed $250, you should request a benefit pre-estimate. To do this, have your dentist complete the dental claim form by: 1) itemizing the dental services recommended, and 2) showing the charge for each dental service. The completed claim form should be submitted to the Claims Administrator. The pre-treatment estimate is designed to eliminate any misunderstanding you might have with respect to your coverage before you begin your dental treatment.

Alternate course of treatment

The plan's alternate course of treatment provision limits covered dental expenses to the least expensive, professionally adequate procedure or course of treatment which, as determined by the Claims Administrator, will produce a professionally adequate result.

Patient-dentist relationship

The pre-treatment review and alternate course of treatment provisions are not intended to interfere in the patient-dentist relationship. They are a means of informing you, in advance, of the services covered and benefits payable under the plan. If you and your dentist select a more costly and elaborate treatment program, you will have to pay the additional cost.

Covered Dental Procedures

Any procedure not listed is excluded unless the treatment provided is for a condition for which one or more of the listed procedures would be appropriate under customary dental practice. In that event, the maximum covered charge will be the amount allowable for the least expensive appropriate listed procedures.

Preventive care services: 90 percent; no deductible

- Oral examinations — initial and periodic oral exam.
- Prophylaxis — cleaning and scaling of teeth, limited to treatment twice per calendar year.

- Dental x-rays — supplementary bitewing x-rays are limited to twice per calendar year; periapical x-rays, single films, initial and additional are limited to 12 per calendar year. To be considered under preventive care, the x-rays listed must be furnished at the same time as other preventive care services. In addition, the timing of services must comply with the stated frequency for other preventive care services.

- Fluorides — topical application of stannous fluoride, limited to one treatment per 12 consecutive months for covered persons under 18.

- Space maintainers, limited to the initial appliance — including installation, fitting and all adjustments within six months of installation, and limited to covered persons under age 16, and excluding all repairs to such.

- Removable appliance therapy or fixed or cemented appliance therapy to control harmful habits, limited to the initial appliance — including installation, fitting and all adjustments within six months of installation, and limited to covered persons under age 16.

- Pit and fissure sealants on permanent molars for persons under age 14, but not more than one in any period of 48 months.

Basic services: 80 percent; after deductible

Diagnostic and therapeutic services

- Dental x-rays — entire denture series, including full mouth, panoramic, occlusal and intra-oral views, limited to once every 36 consecutive months; other x-rays as required for diagnosis when not associated with dental preventive care services and supplies.

- Tests and laboratory examinations — limited to diagnostic casts (study models) and biopsy and examination of oral tissue.

- Oral surgery, including local anesthesia and customary postoperative treatment furnished in connection with oral surgery.

  - Extraction of one or more teeth, including simple, surgical, and impacted removal.

  - Alveolectomy, alveoplasty, stomatoplasty, frenulectomy, excision of pericoronal gingiva, removal of palatal or mandibular tori (exostosis), excision of hyperplastic tissue and oral tissue for biopsy, excision of a tumor or cyst or incision and drainage of an abscess or cyst, tooth replantation.

  - Other oral surgical procedures, including removal of foreign body, closure of oral and salivary fistula, sequestrectomy, maxillary

sinusotomy, suture of soft tissue injury, sialolithotomy, and closure or dilation of salivary duct.

- Periodontics — treatment of periodontal diseases of the gums and tissues of the mouth, limited to gingivectomy, gingival curettage, and osseous surgery (post-surgical visits included), pedicle soft tissue grafts, occlusal adjustments related to periodontal problems, periodontal scaling, and prophylaxis.

- Endodontics — pulp capping, vital pulpotomy and treatment of disease of the nonvital dental pulp, including apicoectomy and medicated paste, and traditional root canal therapy and remineralization.

- Following services and supplies:

  - Emergency palliative treatment.
  - General anesthetics and the administration thereof, when performed in conjunction with surgical procedures only.
  - Antibiotic drug injection by attending dentist.
  - Prescription drugs prescribed by attending dentist.
  - Visits and professional consultation by other than practitioner providing treatment.
  - Professional dental visits after hours.

Restorative services and supplies

- Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations, including pin retention and stainless steel crowns to restore diseased or accidentally broken teeth.

- Recementing of crowns, inlays and bridges.

- Relining of dentures more than six months after the installation of initial or replacement denture, and limited to once per 12-month period.

- Duplication (Rebasing) of dentures more than six months after installation of initial or replacement denture, and limited to once per 36-month period.

- Repair of full and partial denture, acrylic.

- Adjustments to dentures more than six months after installation, or if performed by other than dentist providing appliance.

- Tissue conditioning — more than six months after installation of appliance, and limited to two treatments per arch, once per 12-month period.

Major services: 50 percent; after deductible

Restorative services

- Inlays, onlays, or acrylic, porcelain, or gold crown restorations, cast post and cores, to restore diseased or accidentally broken teeth.

- Replacement of an existing inlay, onlay, or acrylic, porcelain, or gold crown restoration as described above, but if such appliance was installed while covered under this plan, at least five years must have elapsed prior to its replacement or such replacement must be required as result of accidental bodily injury sustained while covered under this plan.

- Repair of crowns and bridges.

- Repair of partial dentures, metal.

Prosthodontic services and supplies

- Initial installation, including adjustments and relines within six months after installation of removable permanent partial or complete permanent dentures, but only if the denture includes replacement of a natural tooth that is extracted while the individual was covered under this plan.

- Initial installation of bridgework, including pontics, inlays, and crowns as abutments, but only if the bridge includes replacement of a natural tooth that is extracted while the individual was covered under this plan.

- Replacement of an existing removable partial or complete denture by a new removable denture. Addition of teeth to an existing removable partial denture.

  These services are covered only if satisfactory evidence is presented that the replacement or addition of teeth is required to replace one or more teeth extracted while the individual was covered under this plan, and:

  – The replacement or addition of teeth is required to replace one or more teeth extracted after the existing removable partial denture was installed;

  – If such denture was installed while the individual was covered under this plan, 36 months have elapsed prior to its replacement; or

  – If necessitated by accidental bodily injury.

- Replacement of an existing bridge by a new bridge, or addition of teeth to an existing bridge. These services are covered only if satisfactory evidence is presented that the replacement or addition of teeth is required to replace one or more teeth extracted while the individual was covered under this plan, and:

  –The replacement or addition of teeth is required to replace one or more

teeth extracted after the existing bridge was installed;

–If such bridge was installed while the individual was covered under this plan, five years have elapsed prior to its replacement; or

–If necessitated by accidental bodily injury.

- Stayplate bases — limited to front teeth only.
- Simple stress breakers.
- Occlusal guards related to periodontal surgery.

Orthodontia services: 50 percent; no deductible

These services are covered only for dependent children under age 19. This means the plan pays benefits up to the 19th birthday only — benefits will cease at that time even if treatment continues.

Coverage is limited to a lifetime maximum of $2,000 for the following:

- Cephalometric film.
- Orthodontic appliances, including impressions, installation, and all adjustments within six months of installation, for:
  - Minor treatment for tooth guidance; and
  - Interceptive orthodontic treatment.

  Comprehensive orthodontic treatment of transitional or permanent detention, including:
  - Initial placement of orthodontic appliance; and
  - Subsequent active orthodontic treatment.

With respect to benefit payments related to initial placement of an orthodontic appliance, charges for services provided shall be deemed a covered dental charge only to the extent of 50 percent of the reasonable and customary charge for the initial banding fee.

Dental Coverage Exclusions

The dental plan does *not* cover:

- Orthodontia, except for services listed under Orthodontic Services of *Covered Dental Procedures* that are provided to dependent children under age 19

- Charges for dental services or supplies that are in excess of what is reasonable and customary or are not a medical or dental necessity
- If the charges are not considered appropriate under the administrative practices commonly adhered to by the Claims Administrator
- Dental care and treatment necessitated by accidental bodily injury to sound natural teeth (See *Summary* in this section.)
- Illness or injury caused by war, by self-inflicted injury, or by participation in a riot or commission of a felony
- Illness or injury that is related to work
- Service furnished for cosmetic purposes
- Replacement of lost or stolen appliance
- Services for initial installation of a partial or full removable denture or fixed bridgework, unless such includes replacement of a natural tooth (or teeth) extracted while covered under the plan
- For appliances, restoration, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting or replacing tooth structure lost as a result of abrasion, or attrition or treatment of disturbances of the temporomandibular joint
- Services not furnished by a dentist or dental hygienist under the supervision of a dentist
- Services furnished by any dental practitioner who is related to the patient or lives in the patient's household
- Services or supplies that are furnished or paid for by the government or provided through government programs, or for which the patient is under no legal obligation to pay

Note: The above is a partial list of exclusions; others may apply.

Claiming Benefits

Generally, when you or a covered dependent becomes eligible for in-network services, your network physician or hospital will automatically submit the claim. However, out-of-network and dental benefits will require you to fill out a claim form. The Claims Administrator for each benefit (medical, prescription drug, dental, and mental health/substance abuse) has a claim

form to use for their services. All Claims Administrators have a toll free number to request claim forms; most also have websites. For example, you can call BlueCross BlueShield for a medical/vision claim form at 1-800-824-6349 or go online to www.bcbsil.com. Forms are also available through the Human Resources Service Center at 1-866-YOURHR3 (968-7473), 24 hours a day.

Before submitting a claim for any expense to which the deductible applies, wait until you have accumulated enough expenses to satisfy the annual deductible requirement.

Claims must be received by the appropriate Claims Administrator before the end of the calendar year following the year in which the expense occurred. For example, 2003 charges must be received by the Claims Administrator no later than December 31, 2004.

Medical

If you need to submit a claim form for medical or vision expenses, follow this procedure:

1. The BlueCross BlueShield Health Insurance Claim Form must be completed in detail and signed at least once per year per claimant. Follow the instructions printed on the form.

Note: Medical expenses for different illnesses or injuries can be reported all on one claim form.

2. Attach hospital and doctor bills to the form:

   - Doctors' bills must include the doctor's name, the patient's full name, the type of service, the date of service, and the amount charged.
   - Hospital bills must include the patient's full name, the type of service, the date of service, and the amount charged.
   - Other medical bills must include the patient's full name, the service given, the date of service, and the amount charged.

   Note: Cancelled checks and bills displaying "balance due," "paid on account," or similar statements are not considered itemized bills and will not be accepted.

3. Sign and date the form.

4. Submit the completed, signed and dated claim form to BlueCross BlueShield, the Claims Administrator for medical benefits.

Benefits for covered hospital and physicians' expenses will be paid directly to the provider of service, unless the submitted bill is marked by the provider as "paid" or is accompanied by other evidence of payment.

Prescription Drug

Prescription drug claims must go to Caremark, the Claims Administrator. Many pharmacies will file claims automatically. If not, you must follow the procedure described below:

1. The Caremark claim form must be completed in detail. Follow the instructions printed on the form.
2. Enclose prescription drug bills with the form. (Prescription drug bills must include the doctor's name, the patient's full name, the type of prescription, the cost, the date, and the prescription number.)

3. Sign and date the form.

4. Submit the completed, signed, dated claim form to Caremark.

Dental

Your dental benefit provides coverage for expenses relating to the dental procedures listed in *Covered Dental Procedures*. (Expenses relating to accidental bodily injury to sound natural teeth are filed as a medical expense.)

Your dentist will normally inform you of his or her proposed course of treatment as well as his or her usual charge. As dental care can be expensive, it is advantageous to both you and your dentist to know the benefits payable by your dental plan before any extensive work is performed. If you elect to obtain a Pre-Treatment Review, the dental claim form is designed to secure advance information in writing and should be submitted by your dentist. The Claims Administrator would indicate the amount payable by your dental coverage and the balance that is your portion of the dentist's charge.
To submit a claim for dental expenses, follow this procedure:

1. Complete the Insured's Information Section, Part I, of the dental claim form in full before taking the form to your dentist. Be sure to sign and date the form. Dental benefits may be paid directly to the provider by signing box 13 on the dental claim form.

2. Ask the dentist to describe the proposed course of treatment and usual charge. If your dentist indicates that your dental needs will exceed $250, you should submit a request for Pre-Treatment Review in the following manner:

   a. Check the box marked "Dentist's Pre-Treatment Estimate." Have the dentist

complete the section describing the proposed treatment plan and expenses.

b. Have the dentist submit the form to PreDent, the dental benefits Claim Administrator for BlueCross BlueShield. The form will be returned promptly to you indicating the benefits the dental plan will provide for your course of treatment.

c. Return the form to the dentist and arrange for completion of your course of treatment.

3. After dental treatment has been completed, have the dentist enter the dates when services were performed. Have the dentist sign and date the form in the space provided. Return the form to PreDent for payment.

Mental Health/Substance Abuse

When you receive care through the United Behavioral Health (UBH) network, you have no claims to file. Rather, you pay a portion of costs for which you are responsible and UBH handles the paperwork.

When you receive care outside the UBH network, you will receive non-network benefits and you may be required to file a claim for reimbursement through UBH. (Claim forms can be obtained by calling UBH at 1-800-888-2998.)

Submitting Claims

Submit claim forms to the appropriate Claims Administrator as follows:

Medical Claim
BlueCross BlueShield of Illinois (PPO)
P.O. Box 1220
Chicago, IL 60690-1220

Prescription Drug Claim
Caremark Inc.
P.O. Box 686005
San Antonio, TX 78268-6005

Dental Claim
PreDent
Plan for Dental Care
P.O. Box 2935
Chicago, IL 60690-2935

Mental Health/Substance Abuse Claim
United Behavioral Health
P.O. Box 23250
Oakland, CA 94623-0250

Claims Procedure

Once your fully completed claim form (for medical, prescription drug, dental, or mental health/substance abuse benefits) has been received, the Claims Administrator for that particular benefit will promptly review your claim and provide a written explanation of the amount and type of benefits that have been paid under plan provisions. If you feel that there has been any misunderstanding, you should contact the appropriate Claims Administrator (see the list above), ask any questions you may have, and provide any additional information that might assist the Claims Administrator in determining the amount of benefits payable. If you are not satisfied with the final manner in which your claim was handled by the Claims Administrator, a personal written claim for review may be made to the company as outlined under claim review in section 8: *Administrative Information*.

Right of Reimbursement

The company has the right to recover any benefit payments made under the plan in cases of accidental injury or illness caused by a third party if such benefits are also recoverable from the third party or its insurer. The employee or dependent must cooperate with the Claims Administrator in filling out the required forms and securing the company's right to recovery. Your claim should be marked if it is the consequence of accident or injury, and copies of all bills, accident reports, and other supporting documentation should be submitted.

Fraudulent Claims

As the covered individual, it is solely your responsibility to complete the appropriate claim form and submit medical and dental claims in accordance with the procedures set forth in your handbook, or as directed by the company from time to time. In completing a claim form you must answer all questions, completely and truthfully, to the best of your knowledge. Deliberate omissions or misrepresentations of fact, falsification of a document or a claim, or commission of any act that may result in the overpayment of insurance benefits shall result in recovery of overpayments and constitute sufficient cause for disciplinary action, including discharge from the company. Former employees or their survivors may suffer loss of future coverage.

Coordination with Other Group Medical Plans

Benefits from all group medical and dental plans that cover you and your dependents will be coordinated, so that benefits are paid up to — but not beyond — actual medical and dental expenses.

Coordination with Other Plans

If you or one of your dependents are enrolled in this plan and also covered under one or more outside group medical or dental coverage arrangements, benefits from all plans will be coordinated. This coordination will make sure that benefits are paid up to, but not in excess of, actual medical and dental expenses.

Also, if one of your dependents qualifies for Medicare or any other government-provided medical benefit for any reason including early disability, benefits will likewise be coordinated. (For employees beyond age 65, see *Coverage When You Work Past Age 65* in this section for more information.)

Here is how coordination works: One plan pays first. It pays full benefits for covered expenses. The second plan in line then pays any difference between what has already been paid and the actual covered expenses — up to its full benefit amounts. Your total benefits from all plans will at least equal your benefits from this plan alone. However, in many cases, coordination results in 100 percent recovery of covered expenses.

An example of coordination would be when the spouse of an employee has coverage through another employer sponsored group plan. Under this circumstance, the other plan would be the primary provider for the spouse and our plan would pay the difference. In such case, the covered expenses probably would be paid at 100 percent between both plans.

Whenever a coordinating plan pays any portion of benefits that our plan might otherwise pay, this helps keep our plan costs down.

Standard insurance practice and the provisions of each plan establish the order in which plans pay, as follows:

- A plan that covers the patient as an active employee pays before a plan that covers the patient as an inactive or retired employee.
- A plan that covers the patient other than as a dependent pays before a plan that covers the patient as a dependent.
- If all plans cover the patient as a dependent, then the plan that covers a patient as a dependent of the person whose birthday falls earlier in the year shall pay first. The plan that covers the patient as a dependent of the person whose birthday falls later in the year shall pay as secondary.
- If the other plans does not provide for determining benefits by birthday as set forth above, then the plan that covers the patient as a dependent of a male person shall pay before the plan covers the patient as a dependent of a female person.

- If no order has been established as set forth above, then the plan that has covered the patient for the longest period of time pays first.
- If the coordination of benefit provisions in the other plan do not follow the same order as this plan, then the other plan will pay first.

The Claims Administrator will automatically change these rules to conform with regulatory requirements or common industry practices.

The Claims Administrator reserves the right to obtain the information needed to administer this provision. The Claims Administrator also reserves the right to recover or pay benefits as necessary to administer this provision.

Remember that you cannot knowingly fail to disclose the existence of other employer coverage or eligibility for government-provided benefits under our plan. (See *Fraudulent Claims* in this section for more information.)

Coverage When You Work Past Age 65

If you remain actively employed beyond your 65th birthday, you and your spouse may continue your coverage under the Medical and Dental Plan's PPO or HMO option. However, you and your spouse should also apply for coverage under Medicare in order to receive the highest level of benefits.

If you continue to work past age 65 and apply for Medicare, our Medical and Dental Plan will coordinate with Medicare unless you have made a written election to the contrary. The Medical and Dental Plan will be your primary insurance and Medicare will pay as secondary. Together, the plans probably will pay most of your covered expenses.

If you have made a written election that Medicare be primary, you must waive coverage under the Medical and Dental Plan (PPO or HMO option). In this case, your medical coverage will be provided solely by Medicare and you may not receive the highest level of benefits possible if you had instead continued coverage under the Medical and Dental Plan with the Medical and Dental Plan as your primary insurance. (You or your spouse cannot be covered under the Medicare Supplement Plan until you retire.) The same rules apply to your spouse with one exception: If your spouse is eligible for coverage under another employer sponsored group plan, our Medical and Dental Plan will be considered secondary to that plan if your spouse has not made a written election that Medicare be primary.

When Medical and Dental Coverage Ends

Coverage under the Medical and Dental Plan normally stops on the last day of the month in which your employment with the company ends (with the

exception of retirement or total disability). Ongoing protection in another form will generally be available to you at that time.

Medical and dental coverage also stops:

- If you stop paying the required participant contributions. (In this case, coverage ends on the last day of the period for which the last contribution is paid.)
- If you take a military leave of absence. (In this case, your dependents who are covered by the plan at the beginning of this leave will continue to be covered during your absence. The company will pay the full cost of benefits for your dependents' coverage during this period.)
- If the plan ends. (The company expects this plan to continue indefinitely but must reserve the right to change or end the plan if necessary.)

Medical and dental coverage for your covered dependents stops when:

- A dependent child becomes 23, or prior to that if the child marries or is no longer a dependent (including no longer depending on you for support).
- A spouse becomes divorced or legally separated from you.
- Your coverage is terminated for any reason listed above except military leave of absence.

Medical and dental coverage can continue during certain periods that you are not actively employed. These include periods when:

- You are disabled and receiving benefits from a company plan.
- You are on layoff or a nonmilitary leave of absence.

For medical and dental coverage to continue during these periods, you must make arrangements for its continuation and continue to pay the required participant contributions.

If you die, coverage for your eligible dependents can continue under certain circumstances. (See *Dependent Coverage When You Die While Employed* or *Dependent Coverage When You Die After Retirement* in this section for more information.)

Coverage for yourself and eligible dependents can also continue after retirement under certain circumstances. (See *Medical Coverage After Retirement* in this section for more information.)

Receiving Benefits If You Are Totally Disabled When Coverage Ends

Benefits for medical expenses continue to be paid according to the plan beyond the date your coverage ends if you or a covered dependent is totally disabled on this date. In this case the plan only continues to cover the illness or injury that is causing the total disability and does not cover medical expenses unrelated to the disability.

Hospitalization and surgical benefits for this illness or injury are paid for a confinement or operation that occurs within three months after coverage ends. However, to qualify for these benefits, total disability from this illness or injury must continue up to the time of the hospital stay or operation.

The plan also pays benefits for other covered expenses of this disabling illness or injury, as long as they are incurred within 12 months after your medical coverage ends.

This extension of benefits upon disability does not apply to HMO participants.

COBRA Continuation Coverage

When group medical and dental coverage for yourself or a dependent ends, you may be able to continue some or all of it as COBRA coverage.

A number of events could cause you or your dependent spouse or child to no longer be covered under the company's Medical and Dental Plan. (There is a list of these events below.) In such cases, an alternative form of coverage can be arranged. This coverage is called COBRA continuation coverage. Federal law requires that it be made available to you. Dependent children who are born or placed for adoption during the first 18 months of COBRA coverage are also eligible to be covered.

Continuation coverage offers the same protection as the company's medical plan. Dental coverage may also be purchased in addition to medical coverage. During the annual open enrollment period, you will continue to have the option to join an HMO. Continuation coverage lasts up to 18, 29, or 36 months, depending on the reason why your plan coverage ended.

Cost of COBRA Continuation Coverage

The full cost of COBRA continuation coverage must be paid by you or the dependent continuing the coverage.

Occasions for Electing COBRA Continuation Coverage

Following is a list of the kinds of events that would cause the company's group coverage on yourself or a dependent to end, and would allow you to elect continuation coverage.

- Your employment is terminated (for any reason but gross misconduct).
- Your work hours are reduced (other than if you go from full-time to part-time status and are eligible for benefits for part-time employees).
- You die.
- You become legally separated or divorced from your spouse.
- Your child is no longer a dependent as defined under the plan.
- The company files Chapter 11 bankruptcy proceedings (for retirees only).

Maximum Time Period for COBRA Continuation Coverage

When coverage ends because your employment is terminated or work hours are reduced, continuation coverage may be extended for up to 18 months. This period may be extended for an additional 11 months if you or your dependent notifies the company that disability benefits under the Social Security Act have been awarded as of the date of termination or reduction in work hours. However, in order to receive the additional 11 months of COBRA continuation coverage, the notice of this Social Security determination must be given to the company prior to the end of the first 18 months. In the event a qualified beneficiary is disabled during the first 60 days of COBRA coverage, benefits may be provided for a total of 29 months if the following conditions are met:

- The initial qualifying event must have been a termination of employment or a reduction in hours of employment, and
- The qualified beneficiary must be determined to have been disabled, as defined by Social Security, within the first 60 days of COBRA coverage, and
- A copy of the determination of disability has been provided to the company within 60 days after the determination is issued and before the expiration of the initial 18-month COBRA coverage period.

When coverage ends because of any of the other events listed above, COBRA continuation coverage may be extended for up to 36 months (up to the date of death for a retiree who has a qualifying event due to bankruptcy of the company).

Notice of Need to Elect COBRA Continuation Coverage

When you think an event has occurred that will cause the company's group coverage for you or your dependent to end, you should act promptly (within 60 days) to let the company know. This is the first step in electing COBRA continuation coverage for yourself or a dependent.

If you become legally separated or divorced from your spouse, or your child is no longer a dependent as defined under the plan, or you are determined to be disabled (or are determined to no longer be disabled) under the Social Security Act, it is your responsibility (or your dependent's) to notify the Human Resources Service Center. You (or your dependent) may do so by calling 1-866-YOURHR3 (968-7473) on business days and pressing zero to speak with a representative. Also, if a second event occurs while you are receiving COBRA continuation coverage (such as your divorce or legal separation, your death or enrollment in Medicare, your child's loss of dependent child status or you or your dependent's becoming disabled under the Social Security Act), it is your responsibility (or your dependent's) to notify the Human Resources Service Center of these events as well at 1-866-YOURHR3 (968-7473).

In the same way, should the company become aware that your group coverage will be ending as a result of one of the listed events, the company will notify you of the opportunity to elect COBRA continuation coverage.

You or your dependents will have a limited time (generally 60 days) in which to respond to the opportunity to elect COBRA continuation coverage. The company will advise you as to what those time limits are when it becomes aware that one of the listed events applies to you or your dependent.

When COBRA Continuation Coverage Ends

Continuation coverage would typically end when the following kind of event occurs:

- No further payments are made for coverage.
- The person first becomes covered under a group health plan or becomes enrolled in Medicare. (Note: If new coverage provided under a group health plan would exclude a pre-existing condition affecting the employee or dependent, COBRA coverage may continue for that person until the 18-, 29-, or 36-month time limit elapses.)
- The 18-, 29-, or 36-month time limit elapses.
- Group health coverage of any kind is no longer offered by the company.

More Information

To get more information about COBRA Continuation Coverage, call the Human Resources Service Center at 1-866-YOURHR3 (968-7473) on business days and press zero to speak with a representative. The Human Resources Service Center may also be contacted at: Peoples Energy
Human Resources - 21st floor
130 E. Randolph Drive
Chicago, IL 60601

Dependent Coverage When You Die While Employed

If you die while you are employed, medical and dental coverage for your surviving spouse and dependent children may continue under certain conditions provided that the required participant contributions for this coverage are paid. In general, coverage for your spouse and children continues until the first of the month following the 90-day period that begins with your date of death.

If you had 10 or more years of service, your spouse and your children may continue medical and dental coverage beyond the 90-day period specified above, unless your spouse is employed and eligible for that employer's medical coverage or is qualified for Medicare or other government-provided benefits.

Once qualified for continuation, coverage ends when your spouse remarries, becomes employed and eligible for that employer's medical coverage, or later qualifies for Medicare or other government-provided benefits.

COBRA continuation coverage may be available under certain circumstances. (See *COBRA Continuation Coverage* in this section).

If your spouse already is enrolled in the company's Medicare Supplement Plan when you die, your spouse may continue coverage under the Medicare Supplement Plan. Your covered children, if any, may continue their medical and dental coverage beyond the 90-day period specified above, if you had 10 or more years of service at retirement.

Coverage of dependent children may continue only for as long as they meet the dependent definition (see *Eligibility and Participation* in the *Health Care Benefits* section) and the surviving spouse remains covered under the plan.

Surviving spouses are required to notify the company immediately if they or their dependent children no longer qualify for coverage. The company may require proof of continued eligibility from time to time.

Medical Coverage After Retirement

If you have completed 10 years of continuous service after attaining age 40, medical and dental coverage can continue after retirement up to age 65. (This requirement was waived for eligible employees who accepted the special retirement offer effective December 1, 2001.) You can receive coverage under Medicare and the Medicare Supplement Plan after that.

Up to Age 65

If you retire prior to age 65, and have completed 10 years of continuous service after attaining age 40, you may continue medical and dental coverage for yourself and eligible dependents. The company will advise you of the contribution amounts.

Your coverage can continue until you become eligible for Medicare at age 65, or earlier if you become disabled. Your spouse's coverage can also continue until your spouse becomes eligible for Medicare at age 65, or earlier if disabled. In either case, eligibility for medical and dental coverage ceases and you must notify the company immediately. Under these circumstances, you or your spouse would become eligible to enroll in the Medicare Supplement Plan. See the *Medicare and Medicare Supplement* section of the handbook for enrollment information.

Your dependents continue to be eligible for medical and dental plan coverage as long as they continue to meet the dependent definitions described under *Eligibility and Participation* in the *Health Care Benefits* section *and* either you and/or your spouse is covered under the Medical and Dental Plan or the Medicare Supplement Plan.

Keep in mind that you still are required to notify the company as soon as your marital status changes or when any of your dependents cease to be eligible for coverage. (Also see *Eligibility and Participation* in the *Health Care Benefits* section for more information).

If you marry or remarry while you are covered by the Medical and Dental Plan, you may enroll your new spouse if he or she is not eligible for Medicare. (A spouse eligible for Medicare may be enrolled in the Medicare Supplement Plan.) You may also enroll any of your spouse's children, provided they meet the dependent qualifications.

Age 65 and After

Medical coverage available to you on and after age 65 is described in the *Medicare and Medicare Supplement* section of this handbook.

Dependent Coverage When You Die After Retirement

If you die after you retire, coverage for your surviving spouse and dependent children may continue under certain conditions, providing that the participant contributions for this coverage are paid.

If your medical and dental coverage ends because of your death, coverage for your spouse and children continues until the first of the month following the 90-day period that begins with your date of death.

If you had 10 or more years of service at retirement, your spouse and your children may continue medical and dental coverage beyond the 90-day period that begins with your date of death, unless your spouse is employed and eligible for that employer's medical coverage or is qualified for Medicare or other government-provided benefits.

Once qualified for continuation, coverage ends when your spouse remarries, becomes employed and eligible for that employer's medical coverage, or later qualifies for Medicare or other government provided benefits.

COBRA continuation coverage may be available under certain circumstances. (See *COBRA Continuation Coverage* in this section for details.)

If your spouse already is enrolled in the company's Medicare Supplement Plan when you die, your spouse may continue coverage under the Medicare Supplement Plan. Your covered children, if any, may continue their medical and dental coverage beyond the 90-day period specified above, if you had 10 or more years of service at retirement.

Coverage of dependent children may continue only for as long as your surviving spouse retains coverage under the Medical and Dental Plan or the Medicare Supplement Plan, and for as long as they continue to meet the dependent definition. See *Eligibility and Participation* in the *Health Care Benefits* section.

Surviving spouses are required to notify the company immediately if they or their dependent children no longer qualify for coverage. The company may require proof of continued eligibility from time to time. See *Requesting Health Care Coverage* in the *Health Care Benefits* section for more information.

EXHIBIT 2

EXHIBIT 3

administrative **information**

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privacy of your health information	9

section 8

Plan Administration

If you have questions or comments about certain benefit plans that are subject to the Employee Retirement Income Security Act (ERISA), you should contact the plan administrator. Legal process should be served on the agent for legal process. Your benefit plans are sponsored by Peoples Energy Corporation and its companies.

Plan Administrator

The plan administrator is responsible for certain benefit plans that are subject to the Employee Retirement Income Security Act (ERISA). The plan administrator interprets provisions of these plans and sees that the plans run smoothly in other ways. The plan administrator has the discretionary authority to determine who is eligible for benefits and the amount of any benefit payable under any of the plans. The plan administrator is:

Retirement and Benefit Plans Committee
c/o Peoples Energy Corporation
130 East Randolph Drive
Chicago, IL 60601
Telephone: (312) 240-4000

Agent for Legal Process

Legal matters about the benefit plans that are subject to ERISA should be addressed to:

Mr. P. Kauffman
Assistant General Counsel and Secretary
c/o Peoples Energy Corporation
130 East Randolph Drive
Chicago, IL 60601
Telephone: (312) 240-4000

Also, legal process may be served on the plan administrator and on the trustee of those plans that have a plan trustee.

Your benefit plans are sponsored by the following companies:

- Peoples Energy Corporation, 130 East Randolph Drive, Chicago, IL 60601
- The Peoples Gas Light and Coke Company, 130 East Randolph Drive, Chicago, IL 60601

- North Shore Gas Company, 3001 Grand Avenue, Waukegan, IL 60085
- Peoples Energy Resources, 130 East Randolph Drive, Chicago, IL 60601
- Peoples Energy Production, 909 Fannin St., Ste. 1300, Houston, TX 77010
- Peoples Energy Services, 205 N. Michigan Ave., Ste. 4216, Chicago, IL 60601 (Group insurance, flexible spending accounts and Capital Accumulation Plan only)

Plans Subject to Collective Bargaining Agreement

Participation in some benefit plans by some employees is determined under a collective bargaining agreement. Copies of the collective bargaining agreements that provide for this participation are available for examination at the plan administrator's office (i.e., in Human Resources). Also, you may obtain your own copies by submitting a written request to the plan administrator and paying a reasonable charge.

Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in Peoples Energy's benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits

  You are entitled to examine—at no charge—at the plan administrator's office and at other specified locations, such as worksites and union halls, during regular business hours, all documents governing the plans, including insurance contracts, administrative agreements and collective bargaining agreements. You may also examine at no charge a copy of the latest annual reports (Form 5500 Series) filed by the plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

  You may obtain, upon written request to the plan administrator, copies of documents governing the operation of the plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual reports (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

  You are entitled to receive—at no charge—a copy of the plans' annual financial reports. The plan administrator is required by law to furnish each participant with a copy of these summary annual reports.

EXHIBIT 3

You may obtain—at no charge—a statement telling you whether you have a right to receive a pension or retirement benefit at normal retirement age and, if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. You must request this statement in writing. The plan administrator is not required to provide it more than once every 12 months.

- Continue Group Health Plan Coverage

You may continue health care coverage for yourself, your spouse or your dependents if you or your dependent(s) lose coverage under the plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review your summary plan description and the documents governing the plans on the COBRA continuation coverage rights rules.

Your group health plan or health insurance issuer should provide you with a certificate of creditable coverage—at no charge—when:

- You lose coverage under the plan,
- You become entitled to elect COBRA continuation coverage, and/or
- Your COBRA continuation coverage ends.

If you do not receive the certificate of creditable coverage, you must request the certificate within 24 months of losing coverage.

Having creditable coverage from another plan may reduce or eliminate any exclusionary periods of coverage for pre-existing conditions under your group health plan. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after you enroll in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called *fiduciaries* of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your pension or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, you can take steps to enforce the above rights. For example, you can file suit in a federal court if you:

- Request a copy of plan documents or the latest annual report from the plan and do not receive it within 30 days. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
- Have a claim for benefits that is denied or ignored, in whole or in part. (You may also file a claim in state court.)
- Disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order.
- Are discriminated against for asserting your rights. (You may also seek assistance from the U.S. Department of Labor.)

You may also seek assistance from the U.S. Department of Labor or file suit in a federal court if it should happen that plan fiduciaries misuse the plan's money.

The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact:

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- The Division of Technical Assistance and Inquiries
  Employee Benefits Security Administration
  U.S. Department of Labor
  200 Constitution Avenue, N.W.
  Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

EXHIBIT 3

Denied Claims

If you file a claim for benefits (see each section for instructions on filing claims) and your claim is denied, the Claims Administrator must send you a written explanation, including:

- The specific reasons the claim was denied. You may request that any document or record that was relied upon to reach the decision to deny benefits be provided at no charge;
- References to the plan provisions upon which the denial is based;
- A description of additional information, if any, that you need to provide to complete or support the claim and an explanation of why the additional information is necessary; and
- An explanation of the appeal procedure under the plan, including your right to bring a claim in federal court.

Filing Claims and Appeals

If a claim for benefits is denied, you may have it reviewed. There are specific steps you must follow. They are summarized below.

For most medical benefits, the initial claim must be made in writing to the provider. Other initial claims may be made to Human Resources. If some or all of your initial claim is going to be denied, you will be notified of that fact in writing. In addition, you will be given a description of the claim review process and told why benefits are being denied. Also, you will be told what additional information is needed from you to strengthen your claim and why that information is necessary.

The table below summarizes the claims review and appeal procedure for medical benefits.

For all other initial claims, generally, you will be informed within 90 days (45 days for disability claims) of the date your claim was received if benefits are to be denied. However, the company is allowed to notify you within those first 90 (or 45) days that an additional 90 days (or up to 60 days for disability claims) is required to consider your claim. If additional time is required, the company will let you know why. You will have 60 days (180 days for disability claims) to appeal the decision, and will be notified within 60-120 days (45-90 for disability claims) of the decision on review.

Medical Claims Review and Appeal Procedures

Type of Claim	First Appeal	Second Appeal	Third Appeal
PPO Urgent Care Claims	Claims Administrator*	Human Resources You will receive oral notice of the decision within 72 hours, written notice within 3 days if more information is requested.	Retirement and Benefit Plans Committee (i.e., the Medical/Health Care Professional Consultant) You may submit your request for review orally or in writing. You will receive an oral or written notice of the decision within 72 hours.
PPO Pre-Service Claims	Claims Administrator*	Human Resources You will receive notice of the decision within 15 days, which may be extended for up to 15 days.	Retirement and Benefits Plans Committee (i.e., the Medical/Health Care Professional Consultant) You must submit your written request for an appeal within 180 days after being notified that your claim was denied by Human Resources. You will receive written notice of the decision within 30 days.
PPO Post-Service Claims	Claims Administrator*	Human Resources You will receive oral notice of the decision within 30 days, which may be extended for up to 15 days.	Retirement and Benefits Plans Committee (i.e., the Medical/Health Care Professional Consultant) You must submit your written request for an appeal within 180 days after being notified that your claim was denied by Human Resources. You will receive written notice of the decision within 60 days.
PPO Concurrent Care Decisions This relates to an ongoing course of treatment and an Adverse Benefit Determination**. Note: Any Adverse Benefit Determination by the plan must be communicated to Human Resources prior to reduction or termination of benefit to allow for an appeal.	Human Resources You will receive notice as follows: Urgent Care: within 24 hours Pre-Service Claims: 15 days Post-Service Claims: 30 days	Retirement and Benefit Plans Committee You will receive notice of the decision as follows: Urgent Care: within 72 hours Pre-Service Claims: 30 days Post-Service Claims: 60 days	
HMO Claims	HMO Administrator Submit a written request for reconsideration to the HMO in the manner outlined in the relevant HMO Certificate or Subscriber Agreement received at the time of	Individual HMO grievance procedures	Illinois Department of Insurance

*The Claims Administrator is BlueCross BlueShield of Illinois.
**Any Adverse Benefit Determination notification will include the following statement: You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency.

Company Service Provisions

Eligibility to participate in certain plans and the amount and duration of certain benefits depends on your accumulated company service, employment status and, in certain cases, your date of employment. The company service provisions described here apply to all benefits described in the handbook except the Capital Accumulation/Thrift Plan, Employee Stock Ownership Plan, Retirement Plan, and Service Annuity System (the pension plan for union employees). Service provisions for these plans are described in the plans' respective sections of this handbook.

For purposes of all other benefit plans, your company service begins on your first day of employment and grows until the date your employment ends. However, if your period of employment is not continuous — due to a temporary separation from the payroll (layoff, leave of absence) or a full separation from the payroll (resignation or release) followed by re-employment — your company service credit may be affected as follows:

Before May 1, 1981

Layoff

Your service continued to accumulate during the first six months of any layoff, but no service credit was given for any additional months of such a layoff.

Approved personal leave of absence

Your service credit continued to accumulate during the first three months of any approved leave of absence, but no credit was given for additional months of such a leave.

Military leave of absence

In general, your service credit continued to accumulate throughout any military leave of absence, provided you returned to work within 90 days of your date of discharge.

Full separation

Service credit that you had earned before a full separation did not carry over to subsequent periods of employment.

May 1, 1981 and After

Layoff

Your service continues to accumulate during the period of a layoff, provided your return to work occurs within 12 months. If you have not returned from layoff by the end of 12 months, you are fully separated from the payroll and your service credit ends as of the effective date of layoff.

Approved personal leave of absence

Your service continues to accumulate during the period of approved leave of absence provided your return to work occurs within 12 months. If you do not return from the leave on the specified date, you are fully separated from the payroll and your service credit ends as of the effective date of the leave. Should a leave period be continued beyond a 12-month period, no further service credit would be accumulated.

Military leave of absence

In general, your service credit continues to build throughout a military leave of absence, provided you return to work within 90 days of discharge.

Full separation

Your service credit ends as of the date of full separation, sometimes called the "severance date" unless such full separation was immediately preceded by a period of layoff or leave of absence. In the latter instances, service credit would end as of the effective date of layoff or leave. If you are subsequently re-employed within the one-year period following such severance date, credit is restored for the prior period of service, but no credit is given for the period of separation. If you are re-employed more than one year after your severance date, you may receive credit for your former service upon completion of one additional year of service, but only if your former service equals or exceeds the period of separation. No credit is granted for the period of separation.

Your service credit may be affected in one other special situation. If you are absent because of illness or injury, your service continues to build as long as you are receiving benefits from a company plan with one exception. Service for purposes of determining the amount of a termination allowance does not accumulate during any time you are receiving benefits from the Long Term Disability Plan.

If you have a question concerning your service with the company as it relates to your benefits, contact the Human Resources Service Center at 1-866-YOURHR3 (968-7473) on business days and press zero to speak with a representative. In the event there is any disagreement between this brief description of company service and the document titled "Regulations for Determining Service," the document will govern. A final decision as to any dispute will be made by the Retirement and Benefit Plans Committee.

Privacy of Your Health Information

Effective April 14, 2003, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that the Peoples Energy Corporation Comprehensive Group Insurance Plan ("the Plan") which includes the following programs: Medical and Dental Plan, Medicare Supplement Plan and Health and Dependent Care Spending Accounts Plan, protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was previously distributed to you and is available on the Intranet or from Human Resources.

The Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

To receive more information about our privacy practices or your rights, please contact the Plan at the following address or phone 1-866-968-7473.

Peoples Energy Corporation
130 East Randolph Drive, 21st Floor
Chicago, Illinois 60601-6207
Attention: HIPAA Privacy Official

EXHIBIT 4

section 2

Health Care Benefits

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Important Information

The following pages give you basic information about your health care benefits. A description of your benefits is included in the plan (legal) document. Should there be any disagreement between the description in your handbook and the legal document, the legal document will govern.

Your health care benefits are sponsored by Peoples Energy Corporation and its companies. For simplicity, the term "company" in this description means all the sponsoring companies as a group.

- Your health care benefits help pay the medical costs of nonoccupational illness and injury. The plan year for these benefits is October 1 through September 30 for IRS purposes; however, you enroll in benefits for the calendar year.
- The company intends that these benefits will remain in effect indefinitely. However, it reserves the right to modify, amend, or discontinue them at any time.

If you communicate to the government about these benefits, identify them with these numbers:

Employer I.D. number: 36-2642766
Plan number: 501

Summary

Medical Coverage - Peoples Energy offers eligible employees, retirees and their dependents the following medical plan options:

- a preferred provider organization (PPO),
- Two health maintenance organizations (HMOs) (in most locations):
  - HMO Plus, a traditional HMO
  - HMO, for which you pay lower premiums, but higher copays for most services when you use them.
- a Health Fund.

Dental Coverage - Peoples Energy also offers two dental PPO options:

- Dental PPO Plus, which has a higher premium and works like a traditional indemnity plan, and
- Dental PPO, which has a lower premium, no deductible and 100% coverage for in-network preventive care, but provides lower coverage when you go out-of-network.

To see how the plans compare at a glance, refer to the benefit plans comparison charts at the back of this section.

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The company also offers the Medicare Supplement Plan, which is designed to supplement your medical coverage after you retire and become eligible for Medicare. Medicare Supplement Plan benefits are based on full Medicare participation (Part A and Part B). Enrollment is voluntary. See the *Medicare and Medicare Supplement* section of this handbook for more information.

Eligibility and Participation

As an employee, you are eligible to elect medical and dental coverage for yourself. You can also elect coverage for your children and your lawful spouse.

During the open enrollment period held in the fall each year, employees can move between the various health plans being offered. Refer to the *Health Care Benefits Comparison Chart* for a general comparison of the benefits of each option under the Medical and Dental Plan. (Please note that the chart features plan highlights, not every feature that you may wish to compare before making a decision.) The Health Care Benefits Comparison Chart is issued annually at open enrollment time and should be kept at the back of this section of your handbook.

Eligibility
You are eligible to enroll in health care coverage on your first day of active full-time or part-time employment. If you are a part-time employee, your coverage is based on you paying the same monthly contribution as full-time employees plus an additional premium based on your scheduled weekly hours. Temporary employees are not eligible for coverage. If you elect coverage for yourself, you can also elect coverage for your eligible dependents.

Eligible dependents include:

- Your lawful spouse, provided you are not legally separated; and
- Your natural or adopted children who are unmarried, under 23 years of age, are not employed on a regular full-time basis, and who continue to be dependent on you for support.
- "Children" also includes stepchildren, foster children and other children who are unmarried, are under age 23, are not employed on a regular full-time basis, and who depend upon your support and live with you in a regular parent-child relationship.
- Additionally, the word "child" includes any child of an employee who is designated as an "alternate recipient" under an order determined by the Retirement and Benefit Plans Committee to be a "qualified medical child support order" in accordance with government regulations. You can obtain more detailed information concerning the relevant procedures on qualified medical child support orders from Human Resources.
- "Other" children may be covered only if the employee has been appointed as guardian of the child by an order of a court of law and the child resides with the employee. "Other" children shall also include any individual who has not attained age 18 and who is placed for adoption with an employee.

In all cases of dependent coverage, the company reserves the right to request evidence of dependent status.

If you and your spouse become eligible for Medicare, your dependent remains eligible for coverage under the Medical and Dental Plan, as long as he/she meets the dependent eligibility rules listed above.

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Coverage Beyond Age 23
Your unmarried children who are mentally retarded or physically handicapped may be covered by this plan on and after age 23 under the following conditions: They must be incapable of self-support and dependent on you for support maintenance because of their retardation or handicap, and they must have been retarded or handicapped and covered by the Medical and Dental Plan prior to age 23.

For coverage to continue, you must present satisfactory proof of the child's retardation or handicap to the Claims Administrator two months prior to the child attaining age 23. If you fail to submit proof prior to the date your child reaches age 23, coverage will terminate on the child's birth date and benefits will not be subsequently reinstated. It is suggested that you contact the Human Resources Service Center at the number listed in the "Program Contacts" section at the front of this handbook at least 90 days before the child's 23rd birthday to learn what type of documentation will be required by the Claims Administrator. The Claims Administrator also has the right to request proof of retardation or handicap at any reasonable time following your child's 23rd birthday. Coverage will continue only for as long as your child remains incapable of self-support, provided that either you or your spouse are covered under the plan.

Coverage When You and Your Spouse are Company Employees
If you and your spouse both work for the company, you can each be covered as employees, *or* one of you can cover the other while the other declines coverage. However, both spouses *cannot* cover each other. All children must be claimed as dependents of either the father or the mother. For other special rules that apply in this situation, call the Human Resources Service Center at the number listed in the "Program Contacts" section at the front of this handbook.

Requesting Health Care Coverage
To request coverage for yourself and your dependents, if applicable, you must complete the enrollment form (Medical and Dental/HMO Subscription and Authorization for Payroll Deduction - Form 1414) and submit to Human Resources. You may cover your dependents only if you retain coverage for yourself. You generally have an opportunity to request coverage at the time of employment, during the annual open enrollment period or if you qualify under the special enrollment provisions described later in this section.

When Health Care Coverage Begins

Plan coverage begins for you and your dependents on your date of hire if enrollment is requested on, before that day or within 14 days of hire. If you have any eligible dependents on the day you become insured, you must enroll them on the same date to cover them at that time. If you enroll within 14 days after the initial date of eligibility for coverage, coverage for you begins on the date of application.

If you are not actually working when coverage is scheduled to begin, coverage will begin (for you and your family) on the date you return to work. Also, if a dependent (other than a newborn) is in the hospital on the date coverage is scheduled to begin, that dependent's coverage will begin on the date hospital confinement ends.

Coverage Changes During the Year
If you acquire a dependent after your health care coverage becomes effective, you must enroll your new dependent within 60 days of the date you obtain a new dependent.

If you enroll your dependents within 60 days of their initial date of eligibility, coverage for your dependents begins on the date of application. (For a newborn, dependent coverage takes effect at birth.)

To avoid delays in processing your family's claims, notify the company as soon as there is an addition to, or a removal from, the list of your eligible dependents on file. Also, keep in mind that you are required to notify the company immediately whenever your marital status changes or when any of your eligible dependent's coverage ends. Notification is made by use of the enrollment form (Form 1414).

If you knowingly submit a claim for a person not qualifying for dependent coverage, you are guilty of submitting a fraudulent claim and subject to disciplinary action, including discharge. (See *Fraudulent Claims* which appears later in this section for more information.) The company reserves the right to review each named dependent's eligibility before claims are processed. If you are not sure if your dependents qualify for coverage, call the Human Resources Service Center Center at the number listed in the *Program Contacts* section at the front of this handbook and speak with a representative.

If you ever want to drop coverage for yourself or any of your covered dependents, you must complete the enrollment form (Form 1414). If you are paying for coverage on a pre-tax basis, you can only drop coverage if you experience a qualifying family status change during the calendar year. You may be allowed to change your election within 31 days (60 days for your dependents) of the date of the qualifying change. If there is no qualifying family status change, you must wait to drop coverage until the next annual open enrollment period.

Late Enrollment
If enrollment for you is requested more than 14 days after the initial date of eligibility, or if enrollment for your dependents is requested more than 60 days after the initial date of eligibility, you or your dependents must wait until the next annual open enrollment period to apply, unless the following special enrollment provisions apply:

Special enrollment provisions
During the year, you or your dependent may enroll in the plan through special enrollment if one of the two following conditions exist:

1) You or your dependent previously declined our coverage and then lost coverage under another plan, *and:*

   You or your dependent was covered under another plan at the time coverage under our plan was offered but you declined our coverage (a signed enrollment Form 1414 declining our coverage must be on file);

   If your prior coverage was COBRA coverage, that coverage must be exhausted; *and*

   Your loss of prior coverage resulted from the ending of employer contributions or a loss of eligibility for coverage, such as termination of employment, reduction in hours, divorce, etc. (You must provide a statement from your previous plan stating your or your dependent's ineligibilty or loss of coverage.)

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If all of the above criteria are met, coverage under our plan will be effective on the first day of the month following the date your completed request for enrollment is received.

2) You previously declined our coverage and then you acquired a dependent through marriage, birth, or adoption. Your request for enrollment must occur within 60 days of one of these events. Coverage will be effective on the first day of the month following request for enrollment or, if earlier, the date of birth, of adoption, or of placement for adoption.

Paying for Medical and Dental Coverage
The company funds trusts to provide for payment of medical and dental benefits for active and retired participants covered under the plan. The cost of the plan is shared between you and the company, with the company paying the major portion.

The company funds union and nonunion trusts to provide for the payment of medical and dental benefits for active and retired participants covered under the plan. Claims Administrators were hired to process claims and assure that benefits are paid properly. Funding amounts recognize future claim costs and other applicable considerations. The Claims Administrators do not guarantee or insure any of the benefits. Company and employee contributions are deposited in the plan's trust funds — The Peoples Energy Corporation Life and Health Benefits Trust for Bargaining Unit Employees and Retirees and The Peoples Energy Corporation Life and Health Benefits Trust for Nonbargaining Unit Employees and Retirees. The funds are managed for the exclusive benefit of plan participants by a trustee.

Medical and Dental Participant Contributions
A participant makes two kinds of monthly contributions, one for the medical portion of the plan and one for the dental portion of the plan.

Your medical and dental coverage contributions are deducted from your paycheck. The amount of your contributions depends on whether you choose employee or retiree only or another level of coverage. Contribution amounts are issued annually during open enrollment. You will be advised whenever a change in costs affects your contributions.

Pre-Tax Payment Opportunity
For active employees, premium contributions can be paid on a pre-tax or after-tax basis. Under the pre-tax contribution program, your monthly premium contributions are deducted from your regular pay before federal, state, and Social Security taxes are taken - the result is that taxes are reduced, and take-home pay is correspondingly increased. By law, the pre-tax contribution is available only to active employees. Employees on layoff status and retirees are not eligible to participate. The opportunity to enroll in the pre-tax contribution program is limited to once a year and, generally, your participation remains in effect for the entire year. New employees can enroll in the program at the time they are hired.

Claiming Benefits
Generally, when you or a covered dependent becomes eligible for in-network services, your network physician or hospital will automatically submit the claim. However, out-of-network and dental benefits will require you to fill out a claim form. The Claims Administrator for each benefit (medical, prescription drug, dental, and mental health/substance abuse) has a claim form to use for their services. See the "Program Contacts" section at the front of this handbook for Claims Administrators toll-free numbers and websites.

Before submitting a claim for any expense to which the deductible applies, wait until you have accumulated enough expenses to satisfy the annual deductible requirement.

Claims must be received by the appropriate Claims Administrator before the end of the calendar year following the year in which the expense occurred. For example, 2007 charges must be received by the Claims Administrator no later than December 31, 2008.

Medical
If you need to submit a claim form for medical or vision expenses, follow this procedure:

1. The Health Insurance Claim Form must be completed in detail and signed at least once per year per claimant. Follow the instructions printed on the form.

   Note: Medical expenses for different illnesses or injuries can be reported all on one claim form.

2. Attach hospital and doctor bills to the form:

   - Doctors' bills must include the doctor's name, the patient's full name, the type of service, the date of service, and the amount charged.
   - Hospital bills must include the patient's full name, the type of service, the date of service, and the amount charged.
   - Other medical bills must include the patient's full name, the service given, the date of service, and the amount charged.

     Note: Cancelled checks and bills displaying "balance due," "paid on account," or similar statements are not considered itemized bills and will not be accepted.

3. Sign and date the form.

4. Submit the completed, signed and dated claim form to the Claims Administrator for medical benefits.

Benefits for covered hospital and physicians' expenses will be paid directly to the provider of service, unless the submitted bill is marked by the provider as "paid" or is accompanied by other evidence of payment.

Prescription Drug
Prescription drug claims must go to Perscription Drug Claims Administrator. Many pharmacies will file claims automatically. If not, you must follow the procedure described below:

1. Complete the claim form in detail. Follow the instructions printed on the form.

2. Enclose prescription drug bills with the form. (Prescription drug bills must include the doctor's name, the patient's full name, the type of prescription, the cost, the date, and the prescription number.)

3. Sign and date the form.

4. Submit the completed, signed, dated claim form.

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Dental
Your dental benefit provides coverage for expenses relating to the dental procedures listed in *Covered Dental Procedures.* (Expenses relating to accidental bodily injury to sound natural teeth are filed as a medical expense.)

Your dentist will normally inform you of his or her proposed course of treatment as well as his or her usual charge. As dental care can be expensive, it is advantageous to both you and your dentist to know the benefits payable by your dental plan before any extensive work is performed. If you elect to obtain a Pre-Treatment Review, the dental claim form is designed to secure advance information in writing and should be submitted by your dentist. The Claims Administrator would indicate the amount payable by your dental coverage and the balance that is your portion of the dentist's charge.

To submit a claim for dental expenses, follow this procedure:

1. Complete the Insured's Information Section, Part I, of the dental claim form in full before taking the form to your dentist. Be sure to sign and date the form. Dental benefits may be paid directly to the provider by signing box 13 on the dental claim form.

2. Ask the dentist to describe the proposed course of treatment and usual charge. If your dentist indicates that your dental needs will exceed $250, you should submit a request for Pre-Treatment Review in the following manner:

    a. Check the box marked "Dentist's Pre-Treatment Estimate." Have the dentist complete the section describing the proposed treatment plan and expenses.

    b. Have the dentist submit the form to the dental benefits Claims Administrator. The form will be returned promptly to you indicating the benefits the dental plan will provide for your course of treatment.

    c. Return the form to the dentist and arrange for completion of your course of treatment.

3. After dental treatment has been completed, have the dentist enter the dates when services were performed. Have the dentist sign and date the form in the space provided. Return the form to the Claims Administrator for payment.

Mental Health/Substance Abuse
When you receive care through in-network, you have no claims to file. Rather, you pay a portion of costs for which you are responsible and the program administrator handles the paperwork.

When you receive care outside the network, you will receive non-network benefits and you may be required to file a claim for reimbursement. (Claim forms can be obtained by calling the number listed in the "Program Contacts" section at the beginning of this handbook.

Submitting Claims
Submit claim forms to the appropriate Claims Administrator as shown in the *Program Contacts* section at the front of this handbook.

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Claims Procedure
Once your fully completed claim form (for medical, prescription drug, dental, or mental health/substance abuse benefits) has been received, the Claims Administrator for that particular benefit will promptly review your claim and provide a written explanation of the amount and type of benefits that have been paid under plan provisions. If you feel that there has been any misunderstanding, you should contact the appropriate Claims Administrator, ask any questions you may have, and provide any additional information that might assist the Claims Administrator in determining the amount of benefits payable.

If you are not satisfied with the final manner in which your claim was handled by the Claims Administrator, a personal written claim for review may be made to the company as outlined under claim review in the *Administrative Information section.*

Right of Reimbursement
The company has the right to recover any benefit payments made under the plan in cases of accidental injury or illness caused by a third party if such benefits are also recoverable from the third party or its insurer. The employee or dependent must cooperate with the Claims Administrator in filling out the required forms and securing the company's right to recovery. Your claim should be marked if it is the consequence of accident or injury, and copies of all bills, accident reports, and other supporting documentation should be submitted.

Fraudulent Claims
As the covered individual, it is solely your responsibility to complete the appropriate claim form and submit medical and dental claims in accordance with the procedures set forth in your handbook, or as directed by the company from time to time. In completing a claim form you must answer all questions, completely and truthfully, to the best of your knowledge. Deliberate omissions or misrepresentations of fact, falsification of a document or a claim, or commission of any act that may result in the overpayment of insurance benefits shall result in recovery of overpayments and constitute sufficient cause for disciplinary action, including discharge from the company. Former employees or their survivors may suffer loss of future coverage.

Coordination with Other Group Medical Plans
Benefits from all group medical and dental plans that cover you and your dependents will be coordinated, so that benefits are paid up to — but not beyond — actual medical and dental expenses.

Coordination with Other Plans
If you or one of your dependents are enrolled in this plan and also covered under one or more outside group medical or dental coverage arrangements, benefits from all plans will be coordinated. This coordination will make sure that benefits are paid up to, but not in excess of, actual medical and dental expenses.

Also, if one of your dependents qualifies for Medicare or any other government-provided medical benefit for any reason including early disability, benefits will likewise be coordinated. (For employees beyond age 65, see *Coverage When You Work Past Age 65* in this section for more information.)

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Here is how coordination works: One plan pays first. It pays full benefits for covered expenses. The second plan in line then pays any difference between what has already been paid and the actual covered expenses — up to its full benefit amounts. Your total benefits from all plans will at least equal your benefits from this plan alone. However, in many cases, coordination results in 100 percent recovery of covered expenses.

An example of coordination would be when the spouse of an employee has coverage through another employer sponsored group plan. Under this circumstance, the other plan would be the primary provider for the spouse and our plan would pay the difference. In such case, the covered expenses probably would be paid at 100 percent between both plans.

Whenever a coordinating plan pays any portion of benefits that our plan might otherwise pay, this helps keep our plan costs down.

Standard insurance practice and the provisions of each plan establish the order in which plans pay, as follows:

- A plan that covers the patient as an active employee pays before a plan that covers the patient as an inactive or retired employee.
- A plan that covers the patient other than as a dependent pays before a plan that covers the patient as a dependent.
- If all plans cover the patient as a dependent, then the plan that covers a patient as a dependent of the person whose birthday falls earlier in the year shall pay first. The plan that covers the patient as a dependent of the person whose birthday falls later in the year shall pay as secondary.
- If the other plans does not provide for determining benefits by birthday as set forth above, then the plan that covers the patient as a dependent of a male person shall pay before the plan covers the patient as a dependent of a female person.
- If no order has been established as set forth above, then the plan that has covered the patient for the longest period of time pays first.
- If the coordination of benefit provisions in the other plan does not follow the same order as this plan, then the other plan will pay first.

The Claims Administrator will automatically change these rules to conform with regulatory requirements or common industry practices.

The Claims Administrator reserves the right to obtain the information needed to administer this provision. The Claims Administrator also reserves the right to recover or pay benefits as necessary to administer this provision.

Remember that you cannot knowingly fail to disclose the existence of other employer coverage or eligibility for government-provided benefits under our plan. (See *Fraudulent Claims* in this section for more information.)

Medicare Coverage When You Work Past Age 65
If you remain actively employed beyond your 65th birthday, you and your spouse may continue your coverage under the Medical and Dental Plans. However, you and your spouse should also apply for coverage under Medicare in order to receive the highest level of benefits.

If you continue to work past age 65 and apply for Medicare, our Medical Plan will coordinate with Medicare unless you have made a written election to the contrary. The Medical Plan will be your primary insurance and Medicare will pay as secondary. Together, the plans probably will pay most of your covered expenses.

If you have made a written election that Medicare be primary, you must waive coverage under the company's Medical Plan. In this case, your medical coverage will be provided solely by Medicare and you may not receive the highest level of benefits possible if you had instead continued coverage under the Medical and Plan with the Medical Plan as your primary insurance. (You or your spouse cannot be covered under the Medicare Supplement Plan until you retire.) The same rules apply to your spouse with one exception: If your spouse is eligible for coverage under another employer sponsored group plan, our Medical Plan will be considered secondary to that plan if your spouse has not made a written election that Medicare be primary.

When Medical and Dental Coverage Ends
Coverage under the Medical and Dental Plans normally stop on the last day of the month in which your employment with the company ends (with the exception of retirement or total disability). Ongoing protection in another form will generally be available to you at that time.

Medical and dental coverage also stops:
If you stop paying the required participant contributions. (In this case, coverage ends on the last day of the period for which the last contribution is paid.)

If you take a military leave of absence. (In this case, your dependents who are covered by the plan at the beginning of this leave will continue to be covered during your absence. The company will pay the full cost of benefits for your dependents' coverage during this period.)

If the plan ends. (The company expects this plan to continue indefinitely but must reserve the right to change or end the plan if necessary.)

Medical and dental coverage for your covered dependents stops when:

- A dependent child becomes 23, or prior to that if the child marries or is no longer a dependent (including no longer depending on you for support).
- A spouse becomes divorced or legally separated from you.
- Your coverage is terminated for any reason listed above except military leave of absence.
- Medical and dental coverage can continue during certain periods that you are not actively employed. These include periods when:
- You are disabled and receiving benefits from a company plan.
- You are on layoff or a nonmilitary leave of absence.

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For medical and dental coverage to continue during these periods, you must make arrangements for its continuation and continue to pay the required participant contributions.

If you die, coverage for your eligible dependents can continue under certain circumstances. (See *Dependent Coverage When You Die While Employed* or *Dependent Coverage When You Die After Retirement* in this section for more information.)

Coverage for yourself and eligible dependents can also continue after retirement under certain circumstances. (See *Medical Coverage After Retirement* in this section for more information.)

Receiving Benefits If You Are Totally Disabled When Coverage Ends
Benefits for medical expenses continue to be paid according to the plan beyond the date your coverage ends if you or a covered dependent is totally disabled on this date. In this case the plan only continues to cover the illness or injury that is causing the total disability and does not cover medical expenses unrelated to the disability.

Hospitalization and surgical benefits for this illness or injury are paid for a confinement or operation that occurs within three months after coverage ends. However, to qualify for these benefits, total disability from this illness or injury must continue up to the time of the hospital stay or operation.

The plan also pays benefits for other covered expenses of this disabling illness or injury, as long as they are incurred within 12 months after your medical coverage ends.

This extension of benefits upon disability does not apply to HMO participants.

COBRA Continuation Coverage
When group medical and dental coverage for yourself or a dependent ends, you may be able to continue some or all of it as COBRA coverage.

A number of events could cause you or your dependent spouse or child to no longer be covered under the company's Medical and Dental Plans. (There is a list of these events below.) In such cases, an alternative form of coverage can be arranged. This coverage is called COBRA continuation coverage. Federal law requires that it be made available to you. Dependent children who are born or placed for adoption during the first 18 months of COBRA coverage are also eligible to be covered.

Continuation coverage offers the same protection as the company's medical plan. Dental coverage may also be purchased in addition to medical coverage. During the annual open enrollment period, you will continue to have the option to join an HMO. Continuation coverage lasts up to 18, 29, or 36 months, depending on the reason why your plan coverage ended.

Cost of COBRA Continuation Coverage
The full cost of COBRA continuation coverage must be paid by you or the dependent continuing the coverage.

Occasions for Electing COBRA Continuation Coverage
Following is a list of the kinds of events that would cause the company's group coverage on yourself or a dependent to end, and would allow you to elect continuation coverage.

- Your employment is terminated (for any reason but gross misconduct).
- Your work hours are reduced (other than if you go from full-time to part-time status and are eligible for benefits for part-time employees).
- You die.
- You become legally separated or divorced from your spouse.
- Your child is no longer a dependent as defined under the plan.
- The company files Chapter 11 bankruptcy proceedings (for retirees only).

Maximum Time Period for COBRA Continuation Coverage
When coverage ends because your employment is terminated or work hours are reduced, continuation coverage may be extended for up to 18 months. This period may be extended for an additional 11 months if you or your dependent notifies the company that disability benefits under the Social Security Act have been awarded as of the date of termination or reduction in work hours. However, in order to receive the additional 11 months of COBRA continuation coverage, the notice of this Social Security determination must be given to the company prior to the end of the first 18 months. In the event a qualified beneficiary is disabled during the first 60 days of COBRA coverage, benefits may be provided for a total of 29 months if the following conditions are met:

- The initial qualifying event must have been a termination of employment or a reduction in hours of employment, and
- The qualified beneficiary must be determined to have been disabled, as defined by Social Security, within the first 60 days of COBRA coverage, and
- A copy of the determination of disability has been provided to the company within 60 days after the determination is issued and before the expiration of the initial 18-month COBRA coverage period.

When coverage ends because of any of the other events listed above, COBRA continuation coverage may be extended for up to 36 months (up to the date of death for a retiree who has a qualifying event due to bankruptcy of the company).

Notice of Need to Elect COBRA Continuation Coverage
When you think an event has occurred that will cause the company's group coverage for you or your dependent to end, you should act promptly (within 60 days) to let the company know. This is the first step in electing COBRA continuation coverage for yourself or a dependent.

If you become legally separated or divorced from your spouse, or your child is no longer a dependent as defined under the plan, or you are determined to be disabled (or are determined to no longer be disabled) under the Social Security Act, it is your responsibility (or your dependent's) to notify the Human Resources Service Center at the number listed in the *Program Contacts* section at the front of this handbook. Also, if a second event occurs while you are receiving COBRA continuation coverage (such as your divorce or legal separation, your death or enrollment in Medicare, your child's loss of dependent child status or you or your dependent's becoming disabled under the Social Security Act),

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it is your responsibility (or your dependent's) to notify the Human Resources Service Center of these events as well.

In the same way, should the company become aware that your group coverage will be ending as a result of one of the listed events, the company or the company's third party administrator (TPA) will notify you of the opportunity to elect COBRA continuation coverage.

You or your dependents will have a limited time (generally 60 days) in which to respond to the opportunity to elect COBRA continuation coverage. The company will advise you as to what those time limits are when it becomes aware that one of the listed events applies to you or your dependent.

When COBRA Continuation Coverage Ends
Continuation coverage would typically end when the following kind of event occurs:

- No further payments are made for coverage.
- The person first becomes covered under a group health plan or becomes enrolled in Medicare. (Note: If new coverage provided under a group health plan would exclude a pre-existing condition affecting the employee or dependent, COBRA coverage may continue for that person until the 18-, 29-, or 36-month time limit elapses.)
- The 18-, 29-, or 36-month time limit elapses.
- Group health coverage of any kind is no longer offered by the company.

More Information
To get more information about COBRA Continuation Coverage, call the Human Resources Service Center.

Dependent Coverage When You Die While Employed
If you die while you are employed, medical and dental coverage for your surviving spouse and dependent children may continue under certain conditions provided that the required participant contributions for this coverage are paid. In general, coverage for your spouse and children continues until the first of the month following the 90-day period that begins with your date of death.

If you had 10 or more years of service, your spouse and your children may continue medical and dental coverage beyond the 90-day period specified above, unless your spouse is employed and eligible for that employer's medical coverage or is qualified for Medicare or other government-provided benefits.

Once qualified for continuation, coverage ends when your spouse remarries, becomes employed and eligible for that employer's medical coverage, or later qualifies for Medicare or other government-provided benefits.

COBRA continuation coverage may be available under certain circumstances. (See *COBRA Continuation Coverage* in this section).

Coverage of dependent children may continue only for as long as they meet the dependent definition (see *Eligibility and Participation* in this section) and the surviving spouse remains covered under the plan.

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Surviving spouses are required to notify the company immediately if they or their dependent children no longer qualify for coverage. The company may require proof of continued eligibility from time to time.

Medical Coverage After Retirement
If you have completed 10 years of continuous service after attaining age 40, medical and dental coverage can continue after retirement up to age 65. (This requirement was waived for eligible employees who accepted the special retirement offer effective December 1, 2001.) You can receive coverage under Medicare and the Medicare Supplement Plan after that.

Up to Age 65
If you retire prior to age 65, and have completed 10 years of continuous service after attaining age 40, you may continue medical and dental coverage for yourself and eligible dependents. The company will advise you of the contribution amounts.

Your coverage can continue until you become eligible for Medicare at age 65, or earlier if you become disabled. Your spouse's coverage can also continue until your spouse becomes eligible for Medicare at age 65, or earlier if disabled. In either case, once you and/or your spouse become eligible for Medicare, eligibility for medical and dental coverage ceases and you must notify the company immediately. Under these circumstances, you or your spouse would become eligible to enroll in the Medicare Supplement Plan. See the *Medicare and Medicare Supplement* section of the handbook for enrollment information.

Your dependents continue to be eligible for medical and dental plan coverage as long as they continue to meet the dependent definitions described under *Eligibility and Participation* in the *Health Care Benefits* section *and* either you and/or your spouse is covered under the Medical and Dental Plan or the Medicare Supplement Plan.

Keep in mind that you still are required to notify the company as soon as your marital status changes or when any of your dependents cease to be eligible for coverage. (Also see *Eligibility and Participation* in the *Health Care Benefits* section for more information).

If you marry or remarry while you are covered by the Medical and Dental Plan, you may enroll your new spouse if he or she is not eligible for Medicare. (A spouse eligible for Medicare may be enrolled in the Medicare Supplement Plan.) You may also enroll any of your spouse's children, provided they meet the dependent qualifications.

Age 65 and After
Medical coverage available to you on and after age 65 is described in the *Medicare and Medicare Supplement* section of this handbook.

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Dependent Coverage When You Die After Retirement
If you die after you retire, coverage for your surviving spouse and dependent children may continue under certain conditions, providing that the participant contributions for this coverage are paid.

If your medical and dental coverage ends because of your death, coverage for your spouse and children continues until the first of the month following the 90-day period that begins with your date of death.

If you had 10 or more years of service at retirement, your spouse and your children may continue medical and dental coverage beyond the 90-day period that begins with your date of death, unless your spouse is employed and eligible for that employer's medical coverage or is qualified for Medicare or other government-provided benefits.

Once qualified for continuation, coverage ends when your spouse remarries, becomes employed and eligible for that employer's medical coverage, or later qualifies for Medicare or other government provided benefits.

COBRA continuation coverage may be available under certain circumstances. (See *COBRA Continuation Coverage* in this section for details.)

If your spouse already is enrolled in the company's Medicare Supplement Plan when you die, your spouse may continue coverage under the Medicare Supplement Plan. Your covered children, if any, may continue their medical and dental coverage beyond the 90-day period specified above, if you had 10 or more years of service at retirement.

Coverage of dependent children may continue only for as long as your surviving spouse retains coverage under the Medical and Dental Plan or the Medicare Supplement Plan, and for as long as they continue to meet the dependent definition. See *Eligibility and Participation* in the *Health Care Benefits* section.

Surviving spouses are required to notify the company immediately if they or their dependent children no longer qualify for coverage. The company may require proof of continued eligibility from time to time. See *Requesting Health Care Coverage* in the *Health Care Benefits* section for more information.

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Medical Coverage

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Medical Coverage: Preferred Provider Option (PPO)

How the PPO Works
A PPO provides medical services at wholesale costs through contracts with a network of doctors and hospitals. Each time you seek medical services, you have the option of choosing any doctor or hospital within or outside of the network. However, you realize larger cost savings if you utilize the in-network, contracted providers.

"In-network" means medical service rendered by a health care provider who is affiliated with the PPO under the Medical Plan to provide health care to employees, retirees and eligible dependents. "Out-of-network" means medical service received from health care providers not affiliated with the PPO.

The PPO offered by Peoples Energy generally pays 90 percent for in-network or 70 percent for out-of-network or combined in-network and out-of-network charges (union) or 80 percent for in-network or 60 percent for out-of-network or combined in-network and out-of-network charges (nonunion).

All in-network medical expenses, except those for mental health/substance abuse and prescription drugs, are paid based on a Schedule of Maximum Allowances determined by the Claims Administrator based on what the participating professional providers have agreed to accept as payment in full for a particular covered service.

All out-of-network expenses are paid based on reasonable and customary, or R&C, charges. An R&C charge is one that does not exceed the general level of charges made by doctors or other providers in a certain geographic area. If you choose out-of-network providers, the plan will not reimburse amounts considered to be more than the R&C amount.

What is Covered
The PPO pays medical expenses due to illness and injury that are not related to work as follows:

- 100 percent in-network/70 percent out-of-network after deductible (union)or 100 percent in-network/60 percent out-of-network after deductible (nonunion) up to $250 per covered person per year for wellness benefits – certain health care costs related to routine screening and preventive services (no deductible requirement in-network)
- 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of hospital room and board and other hospitalization charges
- 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of doctors', surgeons', and many other medical charges including emergency treatment of an accidental injury, after payment of an annual deductible
- 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of charges for preadmission and post-hospital testing, after payment of an annual deductible

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- 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of outpatient surgery fees and operating room charges, after payment of an annual deductible
- 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of doctors' and surgeons' consulting fees for pre-hospital second surgical opinions (no deductible requirement)
- 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of charges incurred for dental care and treatment necessitated by accidental bodily injury to sound natural teeth, after payment of an annual deductible
- 100 percent in-network after $15 copay/50 percent out-of-network, no copay (union and nonunion) for out-patient physician charges in connection with diagnosis or treatment for mental health or substance abuse, including alcohol; subject to lifetime maximum provisions (no deductible requirement)
- 90 percent in-network/50 percent out-of-network (union) or 80 percent in-network/50 percent out-of-network (nonunion) of reasonable and customary charges in connection with inpatient, hospital room and board, and other hospital charges for treatment of mental health or substance abuse, including alcohol; subject to certain length of stay and lifetime maximum provisions (no deductible requirement)
- 90 percent (union) or 80 percent (nonunion) reimbursement for vision care (up to $200 per covered person per year), including routine eye exams, glasses and contact lenses
- The PPO will pay 100 percent of covered medical charges described here once your coinsured covered medical expenses in excess of the deductibles reach the following amounts during the calendar year:
  - For the family as a whole: $2,500 in-network ($4,500 combined in network and out-of-network charges), or
  - For an individual family member: $1,500 in-network ($3,000 combined in-network and out-of-network charges)

The PPO covers the expenses shown above up to a lifetime maximum of $1 million per person, including the treatment of mental health and substance abuse, including alcohol.

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Medical Coverage
The PPO covers most medically necessary charges for illness and injury — provided the illness or injury is not job related. To be defined as medically necessary, the treatment must be legal, not experimental, and ordered by a physician as part of a safe and effective course of treatment that is generally accepted by the American medical community. Custodial care or redundant or preventive treatment will not be considered medically necessary.

The PPO generally pays 90 percent (union) or 80 percent (nonunion) of in-network charges (subject to the Schedule of Maximum Allowances determined by the Claims Administrator) and 70 percent (union) or 60 percent (nonunion) of out-of-network charges. The Schedule of Maximum Allowances represents discounted amounts for services negotiated by BlueCross BlueShield with contracted providers.

All in-network medical expenses, except those for mental health/substance abuse and prescription drugs, are subject to the Schedule of Maximum Allowances. All out-of-network expenses are paid based on reasonable and customary, or R&C, charges.

When Medical Benefits Begin
Benefits for most expenses begin after satisfaction of a deductible requirement.

The Medical Deductible
There are deductibles for an individual and for a family. Benefits begin each calendar year after you pay the specified amount of the medical expenses to which the deductible applies. In other words, a deductible is the amount you must pay, out of your pocket, for covered services before the plan pays any benefits. The deductibles are:

In-Network (union & non-exempt)	Out-of-Network (union & non-exempt)
$200 per person, per year	$400 per person, per year
$400 per person, per year	$800 per person, per year
In-Network (exempt)	**Out-of-Network (exempt)**
$250 per person, per year	$500 per person, per year
$500 per person, per year	$1,000 per person, per year
In-Network (officers)	**Out-of-Network (officers)**
$400 per person, per year	$ 500 per person, per year
$800 per person, per year	$1,000 per person, per year

For families, once the deductible expenses of two or more covered family members total the in-network or out-of-network deductible, all covered family members may begin receiving benefits.

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For example, for a union or non-exempt employee, his or her family's in-network deductible is satisfied if two family members each have $200 of eligible deductible expenses, or if four family members each have $100 of eligible deductible expenses.

If you incur medical expenses both in-network and out-of-network, the higher out-of-network deductible will apply. The in-network deductible goes toward meeting the out-of-network deductible.

The Plan allows a three-month carryover deductible. This means expenses that occur in October, November and December that are applicable to the deductible also count toward satisfaction of the deductible in the following calendar year.

Medical Annual Out-of-Pocket Expense Maximum
Under certain circumstances, a family's medical expenses covered at the 70 percent union/60 percent nonunion (combined in- and out-of-network) or 90 percent union/80 percent nonunion (in-network) rate may cause them to incur out-of-pocket expenses, in excess of the deductibles, that reach the plan's out-of-pocket expense maximums. These maximum amounts are as follows:

In-network	**Out-of-network***
$1,500 per person, per year	$3,000 per person, per year
$2,500 per family, per year	$4,500 per person, per year

* Out-of-pocket expenses for in-network and out-of-network charges can be combined toward reaching the out-of-network maximums.

Once the out-of-pocket expense maximums are met, the plan may pay 100 percent of any additional covered charges for that individual or family for the rest of the year — up to the lifetime maximum benefit.

Out-of-pocket expenses related to dental care or those used to satisfy the deductibles and penalties imposed under the Managed Health Services Program (see Managed Health Services Program in this section for details) do not count toward the out-of-pocket annual maximums. Here is an example for a management employee of how a family member's medical expenses could be covered, in-network, under the plan:

Covered Expenses		Plan Deductible Pays		You Pay
Hospital Charges	$10,000	- - -	$8,000	$2,000
Doctors' Fees	$500	$250	$250	$250
Total	$10,500	$250	$8,250	$2,250

Under this example, the family member incurred a total of $10,500 in-network medical expenses. Because the individual reached the level of $1,500 in out-of-pocket expenses in excess of the deductible for one individual, the plan would then pay future eligible medical expenses incurred by this individual at 100 percent.

If other family members meet the remaining $250 portion of the $500 family deductible, and also incur an additional $250 in covered medical expenses, their subsequent eligible expenses for the calendar year would be reimbursed at 100 percent. This is because the family will have met the in-network deductibles as well as the annual out-of-pocket maximum of $2,500.

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Medical Lifetime Maximum Benefits

The plan pays certain covered medical charges - including prescription charges and charges for inpatient and/or outpatient treatment for mental health and/or substance abuse, including alcohol - up to a lifetime maximum of $1 million per person. When the individual maximum has been reached, coverage for medical expenses under the PPO portion of the Medical Plan ends.

Medical Coverage of and Treatment for Bodily Injury, Illness or Pregnancy

The plan generally pays a major portion of the medical expense for care of bodily injury and illness and for pregnancy. Hospital charges and doctors' fees for inpatient and for outpatient care are included. A Schedule of Maximum Allowances is set on these charges and fees by the Claims Administrator based on what the participating professional providers have agreed to accept as payment in full for a particular covered service. All in-network medical expenses, except those for mental health/substance abuse and prescription drugs, are subject to the Schedule of Maximum Allowances. All out-of-network medical expenses are paid subject to reasonable and customary charges.

Following are two lists that show the kind of hospital charges and doctors' fees typically covered by the plan. One list is for outpatient services and the other is for inpatient care. Each list shows the percentage of expense covered, and whether or not there is a deductible. Check with your Claims Administrator representative for more precise information.

The plan generally pays 90 percent (union) or 80 percent (nonunion) for in-network or 70 percent (union) or 60 percent (nonunion) for combined in-network and out-of-network charges after the deductible of the following inpatient and outpatient expenses and fees subject to the provisions of the Managed Health Services Program (see Managed Health Services Program in this section for details):

Inpatient

- Surgery Fees
- Visits by your physicians
- Consulting specialists
- Obstetrical services (delivery)
- Surgical implants
- Hemodialysis
- Open heart surgery
- Medical treatments given by a qualified doctor
- Room and board
- Private duty registered nurses ordered by your doctor
- Hospital charges for: operating, recovery, delivery and nursery room, x-ray treatments; radioisotopes; oxygen; laboratory services; x-rays; fluoroscopy, EKG; EEG dressing; anesthesia; intravenous fluids; blood and the cost of the administration of blood
- Physical, occupational and speech therapies

The plan may pay 100 percent of covered medical charges described here, if your out-of-pocket expenses in excess of the deductibles reach the annual maximum for the family as a whole or for an individual family member during the calendar year.

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Also, note that under the Managed Health Services Program, described in this section, hospital stays will be reviewed to ensure that they are no longer than necessary.

Outpatient

- Visits to your physician's office
- Visits to consulting specialists
- Physician fees for outpatient surgery
- Outpatient operating room charges and related expenses
- Diagnostic services: x-rays; fluoroscopy; EKG; EEG; clinical isotope services; laboratory tests
- Pre-hospital testing (when performed up to 72 hours before admission)
- Post-hospital testing (when performed up to seven days after hospitalization ends)
- Anesthesia
- Oxygen
- Physical, occupational and speech therapies (subject to $1,000 maximum limit per therapy per calendar year)
- Rental of an iron lung
- Rental of oxygen tent, hospital bed, wheel chair, or similar medical equipment
- Artificial eyes and limbs (one time only)
- Private duty nursing when ordered by your doctor (subject to $1,000 maximum limit per person per month)
- Pre-surgical second opinions

- Mammography screening, as determined by the following schedule:

Age of Insured	Frequency of Mammogram
35 – 39	Baseline mammogram
40 - or older	Annually

The plan may pay 100 percent of covered medical charges described here, if your out-of-pocket expenses in excess of the deductibles reach the annual maximum for the family as a whole or for an individual family member during the calendar year.

Keep in mind that the amount charged in-network by a hospital or doctor will be determined based on the Schedule of Maximum Allowances. Only that much will be covered. Out-of-network charges will be based on reasonable and customary charges.

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Other expenses and fees
Pregnancy is covered in the same way as any other illness or injury. Related services are listed here. Additional information is presented under *Pregnancy,* later in this section.

There are maximum lifetime limits on payment for the inpatient and outpatient treatment of mental health and substance abuse, including alcohol. Therefore, such treatment is not listed here. Instead, it is discussed under the *Mental Health and Substance Abuse, Including Alcohol* section.

The plan covers some specialized kinds of health care facilities and services. These are discussed separately under the sections *Extended Care, Home Health Care* and *Hospice Care.*

Prescription Drug Program
The Prescription Drug Program is designed to provide you and your family a convenient and cost-effective way to obtain prescription medication for short-term or long-term needs. The program gives you two options through which to purchase medically appropriate prescription drugs at a discounted price:

- A participating retail pharmacy, or
- The Mail Service Program.

You can also register online using the information listed in the "Program Contacts" section at the front of this handbook or on your Prescription Drug Card, to take advantage of their online services. The online services allow you to:

- Order refills
- Verify order status
- Check benefit coverage
- Research drug information
- View prescription history
- Locate retail pharmacies
- Access health information

If you have any questions or would like to take advantage of the plan's online services, contact the plan administrator, using the contact information listed in the "Program Contacts" section at the front of this handbook.

There are three types of prescription drugs that your physician may prescribe:

- **Brand-name** - A drug that is approved by the Food and Drug Administration (FDA), and is supplied by one company (the pharmaceutical manufacturer). The drug is protected by a patent and is marketed under the manufacturer's brand name.
- **Formulary** - A drug from a list of the highest quality, most cost-effective drugs that a health plan maintains as a guide for physicians. Caremark will send you a brochure that includes a listing of their formulary drugs.
- **Generic** - After a brand-name drug's patent expires, other companies may produce generic forms of the drug. A generic drug is therapeutically and chemically equivalent to the brand name drug and, by law, must meet the same standards for safety, purity, strength and quality.

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Retail Program
You generally use the Retail Program for short-term prescription drugs. When you use the Retail Program, you are limited to a 30-day supply of your medication. (The number of refills is subject to your doctor's authorization.) After you fill your prescription twice through the Retail Program, you can continue to use the Retail Program and pay a higher percentage, or you can use the Mail Service Program and pay a flat fee (see chart that follows). Although use of the mail service feature is not required, the company encourages you to make use of it whenever possible, given its convenience, security and cost savings to both the participant and the company.

Mail Service Program
You can use the Mail Service Program for maintenance and long-term medications. Maintenance drugs or long-term prescriptions are drugs prescribed for more than 30 days, or drugs taken on a regular or long-term basis, e.g., drugs for high blood pressure, arthritis, heart conditions and diabetes. When you use the Mail Service Program, you receive up to a 90-day supply of your medication. (The number of refills is subject to your doctor's authorization.) Although use of the mail service feature is not required, the company encourages you to make use of it whenever possible, given its convenience, security and cost savings to both the participant and the company.

To receive your prescription, mail your original prescription and your Patient Profile/Order Form to the address listed at in the "Program Contacts" section of this handbook. Your medication will be sent directly to your home. You can order refills and check the status of your order online when you register for their online pharmacy services. Or you can do so by phone. This process can take several weeks, so make sure to plan accordingly.

Costs Through the Prescription Drug Program

	Retail Program (30-day supply)				**Mail Service Program (90-day supply)**	
			Third and subsequent fills			
You Pay	**Greater of 20% or...**		**Greater of 30% or...**		**Flat fee...**	
	Union	Non-union	Union	Non-union	Union	Non-union
Generic	$ 5	$7.50	$10	$20	$10	$15
Formulary (primary drug list)	$10	$20	$20	$40	$15	$30
Brand Name (not on the formulary list)	$25	$35	$50	$60	$30	$45

Once a participant has paid $1,000 out of pocket in a calendar year, any remaining prescriptions will be reimbursed at 100% for the remainder of the calendar year.

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Managed Health Services Program

The Managed Health Services Program is designed to assist you and your family by evaluating the medical necessity of admission to a hospital.

The program is administered by specially qualified registered nurses and Medical Advisors who work with BlueCross BlueShield's Medical Service Advisory Review Unit for the following hospital admissions:

- Pre-Admission Review for all elective and maternity hospital stays
- Admission Review for all emergency hospital stays
- Continued Stay Review and Discharge Planning for all hospital stays

As partners in the effort to maximize our medical benefits, the company and plan participants each have certain responsibilities. Therefore, to assure that you receive the maximum benefit available to you, you must follow the procedures described.

If you fail to follow the procedures described,here, your benefit payment will be reduced. Failure to notify the Medical Service Advisory Review Unit in a timely manner for any elective or emergency admission or failure to comply with review recommendations will result in a separate $400 facility charge, per admission. This amount will not be applied to your deductible or any out-of-pocket maximum.

Elective Admissions - Nonmaternity

Before you or one of your covered dependents schedules nonemergency, inpatient hospitalization, you or your physician (or someone from your physician's office) must notify the plan administrator's Medical Service Advisory Review Unit in advance of the confinement at the number listed in the "Program Contacts" section at the front of this handbook. If it is more convenient, you and your physician can complete and send a hospital Pre-Admission Form to the Unit at least 10 days prior to admission.

The Medical Service Advisory Review Unit's professionals will obtain specific information from your physician, noting specific reasons for your proposed hospitalization and length of stay, and will ensure that the proposed hospitalization meets the requirements of the plan. This review is based on your needs as a patient, physician-developed criteria, and regional hospital patient admission studies.

Upon receipt of full information, the review will be completed, generally within one working day. Written confirmation of the results will be provided to you, your physician, and your hospital. If time is pressing, you and your physician will be contacted by telephone, followed by the usual written confirmation. The Medical Service Advisory Review Unit's staff may recommend to your physician that your treatment be administered in an outpatient setting or that testing be done prior to admission.

Elective Admissions - Maternity

Maternity and related admissions are not entirely unexpected. Therefore, you must notify the Medical Service Advisory Review Unit prior to the time you expect to enter the hospital. You actually may have a scheduled date, if you and your physician have agreed on an elective cesarean section. In all cases, if the date that you or your dependent is actually admitted for maternity reasons is not firmly scheduled, and you have not given notice of the exact date, you, your physician, your family, or someone at the hospital must contact the Medical Service Advisory Review Unit within 48 hours of admission (72 hours if the confinement begins on a Saturday, Sunday, or legal holiday).

EXHIBIT 4

Emergency Admissions
Of course, in an emergency, no one expects you to call before you go into the hospital. Your health and well-being come first, and you should get whatever care your physician recommends. However, you, a family member involved in your health care, your physician, or someone at the hospital must call the plan administrator's Medical Service Advisory Review Unit at the number listed in the "Program Contacts" section at the beginning of this handbook as soon as possible within 48 hours of admission (72 hours if the confinement begins on a Saturday, Sunday, or legal holiday). Once you are hospitalized, your case is reviewed like any other hospitalization under the Pre-Admission Review process.

Continued Stay Review
During your hospital stay, the Medical Service Advisory Review Unit's staff will contact your physician at regular intervals to see if you are remaining in the hospital the expected length of time. If your physician decides that you need to stay in the hospital longer, the request for extension will be reviewed, based on the new information your physician will provide.

If the request for extension is approved, your doctor will be notified by phone. If your physician has not provided satisfactory additional proof of medical appropriateness to support the request for extension, your doctor will be called, and written confirmation will be sent to your physician and your home.

Discharge Planning
Often there are alternatives to an extended hospital stay, and the plan provides coverage for many of these, including hospice, home health care, and extended care facilities. A Medical Service Advisory Review Unit professional will discuss appropriate options with your doctor so that, together, you and your physician can decide what is best for you.

If, in the course of Continued Stay Review or Discharge Planning, you decide to remain in the hospital beyond the number of days deemed reasonably necessary, payment for additional hospital days will be made only if your physician provides satisfactory additional proof of medical necessity.

Requesting Reconsideration from Managed Health Services
Normally, differences of opinion will be easily resolved between your physician and the Medical Advisor who initially reviews your case. However, if at any time in the review process you or your physician disagrees with the result of the review regarding the medical appropriateness of admission or length of stay, reconsideration of the review decision may be requested. Reconsideration is initiated by you or your physician calling or writing to the Claims Administrator. This request should be made in a reasonably prompt manner for timely reconsideration to be given.

If the Claims Administrator denies reconsideration, a written appeal may be made to the company as outlined in the *Administrative Information section.*

EXHIBIT 4

Medical Case Management
When you or your dependent suffers from a long-term or serious illness or injury, this program may be made available to help you explore alternate medical care choices that can offer more efficient use of benefits under the Plan.

In addition to the Managed Health Services Program, the plan offers a special program called Medical Case Management. The types of illnesses and injuries that may be considered appropriate for Medical Case Management include high risk newborns, severe stroke, certain cancers, serious burns or fractures, head injuries, AIDS, multiple sclerosis, and other grave diagnoses.

In the event that you or your dependent suffers from a long-term or serious illness or injury, this program may be made available to help you explore alternate medical care choices that may offer more efficient use of benefits under the plan. In some cases, the Case Management Consultant may offer an option that is an authorized exception to plan provisions. These alternatives will be reviewed with you and your physician. You have the right to accept or reject the proposed alternative course of treatment recommended by the Consultant. In no event, however, will the plan pay benefits for inpatient confinement deemed not medically appropriate through normal hospitalization review by the Managed Health Services Program.

Please remember that appropriate coinsurance percentages and deductibles will be applied in determining benefits. Benefits paid under Medical Case Management are included within and are not in addition to overall individual and family lifetime maximums.

Peoples Energy Corporation, through Medical Case Management and the Managed Health Services program is committed to helping you find the most appropriate care possible.

Wellness Benefits
The plan pays up to $250 for wellness benefits per covered person per year. In addition, the plan pays 100% of the cost of routine mammograms, PSA tests and colonoscopies without a deductible. When you use in-network providers, you do not have to satisfy your deductible before the plan pays benefits. If you use out-of-network providers, your benefits are subject to your deductible and coinsurance. In either case, you must pay costs more than the $250 benefit limit.

Covered services include:

- Office visits for routine physical examinations
- Immunizations (travel-related immunizations not included)
- Routine gynecological examinations
- Routine Pap smears
- Routine mammograms
- Routine PSA tests
- Routine colonoscopies
- Routine labs, x-rays, and blood tests
- Well-child care for children under age six

EXHIBIT 4

Health Solutions℠

Employees enrolled in the PPO and Health Fund can take advantage of Health Solutions℠, a program that helps you take better control of your health. The program offers education on medication usage, early symptom identification, treatment options, diet, nutrition and healthy lifestyles as well as a health assessment and preventive screenings.

In addition you have 24/7 access to a toll-free support line staffed by experienced registered nurses for any questions and concerns you may have. There is no cost to you to use Health Solutions℠ and all your personal health information is kept confidential.

Pregnancy

The medical plan covers pregnancy and childbirth in the same way as an illness or injury. A newborn must be enrolled within 60 days of birth.

Employees and covered dependents are eligible for pregnancy benefits under the medical plan.

The plan covers the medical costs of pregnancy and childbirth (or other termination of pregnancy) in the same way it covers illness and injury.

All hospital inpatient confinements are subject to maternity Pre-Admission Review, Maternity Admission Notification, Continued Stay Review, and Discharge Planning provisions of the Managed Health Services Program.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The employee's new child may also be covered by the plan beginning on his or her date of birth. To secure coverage the employee must notify the company of the birth within 60 days of the birth and complete Form 1414 (Medical Dependent Declaration Section), returning the signed form to Human Resources and subsequently furnishing a birth certificate at the earliest time. You must notify the company of your new family member whether or not you need to change your class of coverage. See Eligibility and Participation in the Overview of Health Care Benefits section for more information about dependent coverage.

EXHIBIT 4

Ambulance and Blood Services

Ambulance - The plan pays 80 percent (in-network and out-of-network) of the cost of professional ambulance service - ground or air transportation - to transport a sick or injured person to and from the hospital after the annual deductible requirement is met.

Blood - The PPO pays 80 percent of charges for blood or blood plasmas and for the administration of blood, under certain circumstances.

Note: Company employees and all annuitants receive blood free of cost through the Life Source-sponsored Blood Replacement Program, which is made possible through regular blood donations by employees. Blood administration expenses are covered by the plan, as stated above.

Home Health Care
If certain care usually given in a hospital is given at home by a qualified agency under an approved plan, the plan pays 90 percent in-network/70 percent outof-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) of the cost of this care - after the in-network annual deductible requirement is met.

In certain limited circumstances, treatment that is normally given in a hospital -for example, certain kinds of therapy and some convalescent care - can be administered at home. The plan covers this care, called "home health care," if it meets these three conditions:

- Care is given by a qualified home health care service or by a hospital authorized to give home health care services,
- Care is administered under a predetermined plan approved by the patient's doctor, and
- The doctor certifies that in the absence of a home health care program, the patient would have to be hospitalized.

If these conditions are met and the annual in-network deductible requirement has been satisfied, the plan pays 90 percent in-network/70 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion).

Covered Charges:

- Part-time nursing care under the supervision of a registered nurse;
- Personal care given by the home health care service;
- Physical, occupational, and speech therapy (subject to $1,000 maximum limit per each therapy per year); and
- Medical supplies, drugs, medicine and laboratory services that would have been covered had the patient been hospitalized, if they are ordered by a doctor.

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Home health care benefits will not be paid for transportation services, costs that are eligible for Medicare, or custodial care (that is, care primarily for a person's physical needs).

Contact the plan's Medical Service Advisory Review Unit (see "Program Contacts" at the front of this handbook) for more detailed information before arranging home health care.

Extended Care
Coverage is provided for skilled nursing care at an extended care facility following a hospital stay. Certain conditions apply.

When skilled nursing care is required following treatment at a hospital, an "extended care facility" may be able to provide it at the most reasonable cost. The plan covers such charges if these conditions are met:

- Confinement must be in a qualified extended care facility that is not primarily engaged in providing custodial care,
- Confinement must begin by means of a direct transfer from a hospital in which the individual was confined for at least three days, and
- Confinement must be for the same condition that caused the individual to be hospitalized.

Charges for the use of an extended care facility are paid by the plan at 90 percent in-network/70 percent out-of-network (union) or 80 percent innetwork/60 percent out-of-network (nonunion) after the deductible. Following is a list of the kind of services that are covered:

- Room and board (limited to 60 days per person per year)
- Nursing care (except private duty), up to $1,000 per person, per month (nonunion)
- Physical, occupational, and speech therapies (subject to $1,000 maximum limit per therapy per year) (nonunion)
- Medical social services under the direction of a physician
- Biologicals, supplies, appliances, and equipment
- Diagnostic and therapeutic services
- Other necessary services generally provided to patients by extended care facilities

Contact the plan administrator's Medical Service Advisory Review Unit for more detailed information before arranging a stay at an extended care facility.

EXHIBIT 4

Hospice Care
Hospice care is specialized care for patients known to be terminally ill. This kind of care will be covered for a six-month period, when a physician certifies that a patient is terminally ill. The benefit may be extended for further periods once the doctor certifies the condition continues.

Inpatient Hospice Care
Inpatient care at a hospice or arranged for by a hospice will be paid at 90 percent in-network/80 percent out-of-network (union) or 80 percent in-network/60 percent out-of-network (nonunion) after deductible. This can include one period of "respite care" per calendar month, where an individual who has been receiving *hospice home care* goes to the *Hospice,* to give family members a break from the strain of providing health care to a terminally ill loved one. Confinements for custodial care will not be covered under the plan. Contact your Claims Administrator claims approver for more detailed information before arranging for Hospice care.

Hospice Home Care Services
This plan will cover services and supplies used in the patient's home, if they are provided or arranged for by a hospice as part of a written hospice care plan. Coverage is at 90 percent in-network/80 percent out-of network (union) or 80 percent in-network/60 percent out-of-network (nonunion) after deductible, and there is a lifetime maximum of $12,500. Following is a list of the kinds of services and supplies covered.

- A doctor's care
- Part-time nursing care
- Physical, respiratory, occupational, and speech therapies (subject to $1,000 maximum limit per therapy per year) (nonunion)
- Counseling by a registered dietician
- Part-time services of a trained home health aide
- Laboratory services, drugs, medication, medical supplies, and appliances prescribed by a physician
- Transportation of the patient to the place where hospice home care will be received

Vision Care
The plan pays 90 percent (union) and 80 percent (nonunion) per person per year - up to $200 - for the costs of routine eye exams, glasses and contact lenses. There is no deductible for vision care benefits. You can visit the vision care provider of your choice.

To receive benefits, you or your provider must file a claim with your medical plan administrator. If you submit the claim, you will be reimbursed for your costs, up to the $200 maximum. Use the standard claim form available from your plan administrator.

Mental Health and Substance Abuse, Including Alcohol
The plan generally pays a major portion of the medical expense for treatment of mental health and substance abuse, including alcohol. Hospital charges and doctor's fees for inpatient and for outpatient care are included. However, strict limits are set on the number of days that will be covered.

For a referral to an in-network provider in your area, call the plan administrator listed in the "Program Contacts" section at the front of the book.

EXHIBIT 4

Inpatient Care
The plan pays in-network charges at 90 percent (union) and 80 percent (nonunion) (50 percent out-of-network), with no deductible, for the treatment of mental health and substance abuse, including alcohol. There is a $1,000 out-of-pocket maximum per person per calendar year. Benefits are payable for no more than 30 days of confinement in a calendar year for each covered person, except for treatment of substance abuse, which is limited to only a second confinement in a lifetime after at least 5 years have passed after the first confinement.

Outpatient Care
In-network physician charges for outpatient treatment of mental health and substance abuse, including alcohol, are covered at 100 percent of reasonable and customary charges subject to a $15 copay per visit. Out-of-network treatment is covered at 50 percent of reasonable and customary charges. There is a limit of 30 visits in a calendar year for each covered person.

Lifetime Maximum Benefits
For each individual, benefits paid for treatment of mental health and substance abuse, including alcohol, are included in the overall individual lifetime maximum, subject only to a 60-day inpatient lifetime maximum for each covered person.

Psychiatric and Substance Abuse Case Review
Psychiatric and Substance Abuse Case Review is provided by the administrator of the mental health and substance abuse benefits provided under the Medical Plan. The purpose of Psychiatric and Substance Abuse Case Review is to help you make the most of your benefits for inpatient treatment of mental health and substance abuse, including alcohol. Related cases are reviewed by a Psychiatric and Substance Abuse Case Review Specialist.

Hospital confinements for mental health and substance abuse, including alcohol, are subject to all elements of the Managed Health Services Program review process, including penalties for noncompliance described under that section. This means that, in all cases, medical appropriateness must be effectively demonstrated for inpatient confinement to make certain that you or your dependent receives the maximum level of benefits for which you are eligible under the plan.

If you or a dependent is hospitalized for treatment of mental health and/or substance abuse, including alcohol, notify the plan administrator's intake counselor, at the number listed in the "Program Contacts" section at the beginning of this handbook. Intake counselors are available 24 hours, seven days a week. A Psychiatric and Substance Abuse Case Review Specialist will review the case for necessity of admission and appropriate length of stay. During the course of confinement, the Specialist may recommend alternative medical care choices that offer more efficient use of benefits provided under the plan. In some cases, these alternatives may involve authorized exceptions to plan provisions. These will be reviewed with you and your physician. You have the right to accept or reject the proposed alternate course of treatment recommended by the Specialist. In no event, however, will the plan pay benefits for inpatient confinement deemed not medically appropriate through normal hospitalization review by the Specialist.

Benefits paid under Psychiatric and Substance Abuse Case Review are included in the lifetime maximum benefit for mental health and substance abuse available as part of the overall individual lifetime maximum.

EXHIBIT 4

Medical Coverage Exclusions
The Medical and Dental Plan does not cover the following:

- Charges for medical services and supplies that are in excess of the Schedule of Maximum Allowances established by the Plan or that are in excess of reasonable and customary charges (See Medical and Dental Plan Details in this section for an explanation of the Schedule of Maximum Allowances.)
- Charges for medical services and supplies that are not medically necessary (except for mammogram screening, vision and wellness benefits)
- Charges not considered appropriate under the administrative practices commonly adhered to by the Claims Administrators
- Illness or injury that is related to work
- Treatment or hospitalization that is not approved by a qualified doctor
- Cosmetic surgery unless it is made necessary by accidental injury that occurs while you are insured
- Dental treatment other than the treatment for accidental bodily injury to sound natural teeth
- Hearing aids - or the examination to prescribe them
- Care that is primarily custodial in nature, such as extended care or nursing home care
- Illness or injury caused by war, by self-inflicted injury, or by participation in a riot or commission of a felony
- Services provided by any medical practitioner who is related to the patient or lives in the patient's household
- Medical services or supplies that are furnished or paid for by the government or provided through government programs, or for which the patient is under no legal obligation to pay

Note: The above is a partial list of exclusions; others may apply.

EXHIBIT 4

The HealthFund

The HealthFund option provides flexible comprehensive coverage that blends the advantages of a PPO plan with a company-sponsored HealthFund you use to pay eligible expenses.

How the HealthFund Works
The plan pays 100% of preventive care expenses up to $250 per person in addition to offering free routine mammograms, prostate cancer and colonoscopy screenings when using in-network providers. And you have the freedom to choose referral-free access to an expansive network of physicians and hospitals at a discount as well as the ability to seek out-of-network care.

At the start of each plan year, Peoples Energy establishes a fund for you and your family that you can use to cover eligible, contracted medical and prescription drug expenses. For employees hired during the year, the fund is pro-rated. If you spend all the money in your fund, you must then meet a deductible before the plan pays 90% of in-network services and 70% of out-of-network services and copayments for prescription drugs.

Any money left over in the fund may be rolled over to cover medical expenses in subsequent years, if you elect to stay in the plan.

Phase One: The Fund
The plan pays 100% of preventive care expenses up to $250 per person in addition to offering free routine mammograms, prostate cancer and colonoscopy screenings. And at the start of each plan year, Peoples Energy establishes a fund for you and your family that you can use to cover eligible, contracted medical and prescription drug expenses.

You're given a HealthFund of:
$ 500 for single coverage
$ 750 for employee plus one
$1,000 if you elect family coverage.

If you do not spend all of the money in your fund, it rolls over to increase the next year's fund balance as long as you stay in the plan. If you do spend all the money in your fund, you then must satisfy a deductible.

Phase Two: The Deductible
Once the fund is spent, you pay for eligible, contracted medical expenses and prescription drug costs until the deductible is met.

In-network deductible is:
$1,000 for single coverage
$1,500 for Employee +1
$2,000 for Family

Out-of-network deductible is:
$1,500 for single coverage
$2,250 for Employee+1
$3,000 for family coverage

Phase Three: Coinsurance
Once you meet your deductible, you pay coinsurance of 10% for in-network service and 30% for out-of-network care for your remaining medical expenses and copayments for prescription drugs at the same rate as the PPO Plan.

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Phase Four: Out-of-Pocket Maximum
If your yearly expenses exceed the coinsurance maximum, the plan pays 100% of your coverage for all eligible medical expenses. (Prescription drug copays do not count against the out-of-pocket maximum.)

For Example....
Here are three claim examples, one from each coverage category:

Example #1 Single Retiree: Jill Jones
Jill is fairly healthy and occasionally visits doctors for minor health issues.

Jill's HealthFund: Year 1

Fund Allocation	$ 500
Expenses: • Ob/Gyn visit $ 200 *(paid under preventive care benefit at 100%)* • Lab test $ 50 *(paid under preventive care benefit at 100%)* • Prescription drugs $ 100	 0 0 (100)
Total Out-of-Pocket Costs	-0-
Fund Rollover to Year 2	**$ 400**

Jill's HealthFund: Year 2

Fund Balance $400 from Year One + $500 from Year Two	$ 900
Expenses: • Ob/Gyn visit $200 *(paid under preventive care benefit at 100%)* • Dermatologist visits $275 • Doctor sick visit $100 • Prescription drugs $325	 0 (275) (100) (325)
Total Out-of-Pocket Costs	-0-
Fund Rollover to Year 3	**$ 200**

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Example #2 Retiree + One: Peter and Jane Palmer
Peter and Jane are married, have no children and relatively few medical expenses beyond occasional trips to a specialist.

The Palmer's HealthFund: Year 1

Fund Allocation			$ 750
Expenses:			
• Routine physical	$110	*(paid under preventive care benefit at 100%)*	0
• Ob/Gyn visit	$175	*(paid under preventive care benefit at 100%)*	
• Three specialist visits	$240		(240)
• Prescription drugs	$190		(190)
Total Out-of-Pocket Costs			-0-
Fund Rollover to Year 2			**$ 320**

The Palmer's HealthFund: Year 2

Fund Balance $320 from Year One + $750 for Year Two			$1,070
Expenses:			
• Routine physical	$120	*(paid under preventive care benefit at 100%)*	0
• Ob/Gyn visit	$180	*(paid under preventive care benefit at 100%)*	0
• Five specialist visits	$400		(400)
• Prescription drugs	$175		(175)
Total Out-of-Pocket Costs			-0-
Fund Rollover to Year 3			**$ 495**

Example #3 - Family Coverage: Andrew Smith
Andrew is married with two children. The Smiths' are healthy, but will experience a major surgery during their second year of coverage:

The Smith Family's HealthFund: Year 1

Fund Allocation			$1,000
Expenses:			
• Physical therapy	$500		(500)
• Preventive office visits	$750	*(paid under preventive care benefit at 100%)*	0
• Lab tests	$ 50	*(paid under preventive care benefit at 100%)*	0
• Prescription drugs	$100		(100)
Total Out-of-Pocket Costs			-0-
Fund Rollover to Year 2			$ **400**

EXHIBIT 4

The Smiths Family's HealthFund: Year 2

Fund Balance $400 from Year One + $1,000 for Year 2	$ 1,400
Expenses: • Hospital/surgery fees $14,300 • Physician office visits $ 300 • Preventive office visits $ 250 *(paid under preventive care benefit at 100%)*	(14,600) *The fund is spent, but then the next phases of coverage kick in...*
Paid Out-of-Pocket for Deductible	$2,000
Paid Out-of-Pocket for Coinsurance (10% of $11,200 up to $3,000 Coinsurance Maximum)	$1,120
Total Out-of-Pocket Costs	$3,120
Fund Rollover to Year 3	$ -0-

Advantages of the Health Fund

- You have freedom to choose how you receive care.
- If you are healthy and only occasionally require medical services beyond preventive care, because the plan pays first, you may experience no incremental expense for medical care beyond the premium and even roll over unused funds to increase the next year's balance.

Disadvantages of the Health Fund

- Those who have an ongoing health condition for which they take expensive medication may not want to enroll in this option, because prescription drugs do not count toward the deductible.

What is Covered

The plan pays medical expenses due to illness and injury that are not related to work as follows:

- 100 percent in-network/70 percent out-of-network up to $250 per covered person per year for wellness benefits – certain health care costs related to routine screening and preventive services.
- 90 percent in-network/70 percent out-of-network of hospital room and board and other hospitalization charges after Health Fund is spent and deductible is met.
- 90 percent in-network/70 percent out-of-network of doctors', surgeons', and many other medical charges including emergency treatment of an accidental injury, after Health Fund is spent and deductible is met.
- 90 percent in-network/70 percent out-of-network of charges for preadmission and post-hospital testing, after Health Fund is spent and deductible is met.
- 90 percent in-network/70 percent out-of-network of outpatient surgery fees and operating room charges, after Health Fund is spent and deductible is met.

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- 90 percent in-network/70 percent out-of-network of doctors' and surgeons' consulting fees for pre-hospital second surgical opinions.
- 90 percent in-network/70 percent out-of-network of charges incurred for dental care and treatment necessitated by accidental bodily injury to sound natural teeth, after Health Fund is spent and deductible is met.
- 100 percent in-network after $15 copay/50 percent out-of-network, no copay for out-patient physician charges in connection with diagnosis or treatment for mental health or substance abuse, including alcohol; subject to lifetime maximum provisions (no deductible requirement).
- 90 percent in-network/50 percent out-of-network of reasonable and customary charges in connection with inpatient, hospital room and board, and other hospital charges for treatment of mental health or substance abuse, including alcohol; subject to certain length of stay and lifetime maximum provisions (no deductible requirement).
- 90 percent (union) or 80 percent (nonunion) reimbursement for vision care (up to $200 per covered person per year), including routine eye exams, glasses and contact lenses.

Union

- 80 percent for each of the first two retail prescription drug fills (but not less than $25 for brand name, $10 for formulary, $5 for generic); 70 percent for third and subsequent retail prescription fills (but not less than $50 for brand name, $20 for formulary, $10 for generic); $30 copay (brand name), $15 copay (formulary), $10 copay (generic) for mail service prescription drugs.

Nonunion

- 80 percent for each of the first two retail prescription drug fills (but not less than $35 for brand name, $20 for formulary, $7.50 for generic);
- 70 percent for third and subsequent retail prescription fills (but not less than $60 for brand name, $40 for formulary, $20 for generic);
- $30 copay (brand name), $20 copay (formulary), $10 copay (generic) for mail service prescription drugs.

The plan covers the expenses shown above up to a lifetime maximum of $1 million per person, including the treatment of mental health and substance abuse, including alcohol.

Medical Coverage

The plan covers most medically necessary charges for illness and injury - provided the illness or injury is not job related. To be defined as medically necessary, the treatment must be legal, not experimental, and ordered by a physician as part of a safe and effective course of treatment that is generally accepted by the American medical community. Custodial care or redundant or preventive treatment will not be considered medically necessary.

The plan generally pays 90 percent of in-network charges and 70 percent of out-of-network charges. The Schedule of Maximum Allowances represents discounted amounts for services negotiated by the Plan with contracted providers.

All in-network medical expenses, except those for mental health/substance abuse and prescription drugs, are subject to the Schedule of Maximum Allowances. All out-of-network expenses are paid based on reasonable and customary, or R&C, charges.

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The Medical Deductible
There are deductibles for each coverage level. Benefits begin each calendar year after you pay the specified amount of the medical expenses to which the deductible applies. In other words, a deductible is the amount you must pay, out of your pocket, for covered services before the plan pays any benefits. The deductibles are:

In-Network:	$1,000 per year employee $1,500 per year employee +1 $2,000 per year family
Out of-Network:	$1,500 per year employee $2,250 per year employee +1 $3,000 per year family

Medical Annual Out-of-Pocket Expense Maximum
Under certain circumstances, your medical expenses covered may cause them to incur out-of-pocket expenses, in excess of the deductibles, that reach the plan's out-of-pocket expense maximums. These maximum amounts are as follows:

In-network:	$1,500 per person, per year $2,500 per family, per year
Out-of-network*	$3,000 per person, per year $4,500 per family, per year

**Out-of-pocket expenses for in-network and out-of-network charges can be combined toward reaching the out-of-network maximums.*

Once the out-of-pocket expense maximums are met, the plan may pay 100 percent of any additional covered charges for that individual or family for the rest of the year - up to the lifetime maximum benefit.

Out-of-pocket expenses related to dental care or those used to satisfy the deductibles and penalties imposed under the Managed Health Services Program (see Managed Health Services Program in this section for details) do not count toward the out-of-pocket annual maximums.

Medical Lifetime Maximum Benefits
The plan pays certain covered medical charges - including prescription charges and charges for inpatient and/or outpatient treatment for mental health and/or substance abuse, including alcohol - up to a lifetime maximum of $1 million per person. When the individual maximum has been reached, coverage for medical expenses under the Health Fund portion of the Medical Plan ends.

Medical Coverage of and Treatment for Bodily Injury, Illness or Pregnancy
The plan generally pays a major portion of the medical expense for care of bodily injury and illness and for pregnancy. Hospital charges and doctors' fees for inpatient and for outpatient care are included. A Schedule of Maximum Allowances is set on these charges and fees by the Claims Administrator based on what the participating professional providers have agreed to accept as payment in full for a particular covered service. All in-network medical expenses, except those for mental health/substance abuse and

EXHIBIT 4

prescription drugs, are subject to the Schedule of Maximum Allowances. All out-of-network medical expenses are paid subject to reasonable and customary charges.

Following are two lists that show the kind of hospital charges and doctors' fees typically covered by the plan. One list is for inpatient services and the other is for outpatient care. Each list shows the percentage of expense covered, and whether or not there is a deductible. Check with your Claims Administrator representative for more precise information.

The plan generally pays 90 percent for in-network or 70 percent out-of-network charges after the fund is exhausted and after the deductible of the following in patient and outpatient expenses and fees subject to the provisions of the Managed Health Services Program (see Managed Health Services Program section for details):

Inpatient

- Surgery fees
- Visits by your physicians
- Consulting specialists
- Obstetrical services (delivery)
- Surgical implants
- Hemodialysis
- Open heart surgery
- Medical treatments given by a qualified doctor
- Room and board
- Private duty registered nurses ordered by your doctor
- Hospital charges for: operating, recovery, delivery and nursery room, x-ray treatments; radioisotopes; oxygen; laboratory services; x-rays; fluoroscopy, EKG; EEG dressing; anesthesia; intravenous fluids; blood and the cost of the administration of blood
- Physical, occupational and speech therapies

The plan may pay 100 percent of covered medical charges described here, if your out-of-pocket expenses in excess of the deductibles reach the annual maximum for the family as a whole or for an individual family member during the calendar year. (See Medical and Dental Plan Details for more information.)

Also, note that under the Managed Health Services Program, described in this section, hospital stays will be reviewed to ensure that they are no longer than necessary.

Outpatient

- Visits to your physician's office
- Visits to consulting specialists
- Physician fees for outpatient surgery
- Outpatient operating room charges and related expenses
- Diagnostic services: x-rays; fluoroscopy; EKG; EEG; clinical isotope services; laboratory tests
- Pre-hospital testing (when performed up to 72 hours before admission)
- Anesthesia
- Oxygen
- Physical, occupational and speech therapies (subject to $1,000 maximum limit per therapy per calendar year)
- Rental of an iron lung
- Rental of oxygen tent, hospital bed, wheel chair, or similar medical equipment
- Artificial eyes and limbs (one time only)
- Private duty nursing when

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- Post-hospital testing (when performed up to seven days after hospitalization ends)

ordered by your doctor (subject to $1,000 maximum limit per person per month)
- Pre-surgical second opinions

- Mammography screening, as determined by the following schedule:

Age of Insured	Frequency of Mammogram
35 – 39	Baseline mammogram
40 - 49	Every two years
50 or older	Annually

The plan may pay 100 percent of covered medical charges described here, if your out-of-pocket expenses in excess of the deductibles reach the annual maximum for the family as a whole or for an individual family member during the calendar year. (See Medical and Dental Plan Details in this section for more information.)

Keep in mind that the amount charged in-network by a hospital or doctor will be determined based on the Schedule of Maximum Allowances. Only that much will be covered. Out-of-network charges will be based on reasonable and customary charges.

Other expenses and fees
Pregnancy is covered in the same way as any other illness or injury. Related services are listed here. Additional information is presented under *Pregnancy,* later in this section.

There are maximum lifetime limits on payment for the inpatient and outpatient treatment of mental health and substance abuse, including alcohol. Therefore, such treatment is not listed here. Instead, it is discussed under the *Mental Health and Substance Abuse, Including Alcohol* section.

The plan covers some specialized kinds of health care facilities and services. These are discussed separately under the sections *Extended Care, Home Health Care* and *Hospice Care.*

Prescription Drug Program
The Prescription Drug Program is designed to provide you and your family a convenient and cost-effective way to obtain prescription medication for short-term or long-term needs. The program gives you two options through which to purchase medically appropriate prescription drugs at a discounted price:

- A participating retail pharmacy, or
- The Mail Service Program.

You can also register online using the information listed in the "Program Contacts" section at the front of this handbook or on your Prescription Drug Card, to take advantage of their online services. The online services allow you to:

- Order refills
- Verify order status
- Check benefit coverage

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- Research drug information
- View prescription history
- Locate retail pharmacies
- Access health information

If you have any questions or would like to take advantage of the plan's online services, contact the plan administrator, using the contact information listed in the "Program Contacts" section at the front of this handbook.

There are three types of prescription drugs that your physician may prescribe:

- **Brand-name** - A drug that is approved by the Food and Drug Administration (FDA), and is supplied by one company (the pharmaceutical manufacturer). The drug is protected by a patent and is marketed under the manufacturer's brand name.
- **Formulary** - A drug from a list of the highest quality, most cost-effective drugs that a health plan maintains as a guide for physicians. Caremark will send you a brochure that includes a listing of their formulary drugs.
- **Generic** - After a brand-name drug's patent expires, other companies may produce generic forms of the drug. A generic drug is therapeutically and chemically equivalent to the brand name drug and, by law, must meet the same standards for safety, purity, strength and quality.

Retail Program
You generally use the Retail Program for short-term prescription drugs. When you use the Retail Program, you are limited to a 30-day supply of your medication. (The number of refills is subject to your doctor's authorization.) After you fill your prescription twice through the Retail Program, you can continue to use the Retail Program and pay a higher percentage, or you can use the Mail Service Program and pay a flat fee (see chart that follows). Although use of the mail service feature is not required, the company encourages you to make use of it whenever possible, given its convenience, security and cost savings to both the participant and the company.

Mail Service Program
You can use the Mail Service Program for maintenance and long-term medications. Maintenance drugs or long-term prescriptions are drugs prescribed for more than 30 days, or drugs taken on a regular or long-term basis, e.g., drugs for high blood pressure, arthritis, heart conditions and diabetes. When you use the Mail Service Program, you receive up to a 90-day supply of your medication. (The number of refills is subject to your doctor's authorization.) Although use of the mail service feature is not required, the company encourages you to make use of it whenever possible, given its convenience, security and cost savings to both the participant and the company.

To receive your prescription, mail your original prescription and your Patient Profile/Order Form to the address listed at in the "Program Contacts" section of this handbook. Your medication will be sent directly to your home. You can order refills and check the status of your order online when you register for their online pharmacy services. Or you can call do so by phone. This process can take several weeks, so make sure to plan accordingly.

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Costs Through the Prescription Drug Program
Perscription drug costs are eligible for reimbursement from the Health Fund, but they do not count toward the deductible. Once the deductible is met the following copays apply:

	Retail Program (30-day supply)				Mail Service Program (90-day supply)	
			Third and subsequent fills			
You Pay	**Greater of 20% or...**		**Greater of 30% or...**		**Flat fee...**	
	Union	Non-union	Union	Non-union	Union	Non-union
Generic	$ 5	$7.50	$10	$20	$10	$15
Formulary (primary drug list)	$10	$20	$20	$40	$15	$30
Brand Name (not on the formulary list)	$25	$35	$50	$60	$30	$45

Managed Health Services Program
The Managed Health Services Program is designed to assist you and your family by evaluating the medical necessity of admission to a hospital.

The program is administered by specially qualified registered nurses and Medical Advisors who work with plan's Medical Service Advisory Review Unit for the following hospital admissions:

- Pre-Admission Review for all *elective* and *maternity* hospital stays
- Admission Review for all *emergency* hospital stays
- Continued Stay Review and Discharge Planning for *all hospital stays*

As partners in the effort to maximize our medical benefits, the company and plan participants each have certain responsibilities. Therefore, to assure that you receive the maximum benefit available to you, you must follow the procedures described.

If you fail to follow the procedures described ,here, your benefit payment will be reduced. Failure to notify the Medical Service Advisory Review Unit in a timely manner for any elective or emergency admission or failure to comply with review recommendations will result in a separate $400 facility charge, per admission. This amount will not be applied to your deductible or any out-of-pocket maximum.

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Elective Admissions - Nonmaternity
Before you or one of your covered dependents schedules nonemergency, inpatient hospitalization, you or your physician (or someone from your physician's office) must notify the plan administrator's Medical Service Advisory Review Unit in advance of the confinement at the number listed in the "Program Contacts" section at the front of this handbook. If it is more convenient, you and your physician can complete and send a hospital Pre-Admission Form to the Unit at least 10 days prior to admission.

The Medical Service Advisory Review Unit's professionals will obtain specific information from your physician, noting specific reasons for your proposed hospitalization and length of stay, and will ensure that the proposed hospitalization meets the requirements of the plan. This review is based on your needs as a patient, physician-developed criteria, and regional hospital patient admission studies.

Upon receipt of full information, the review will be completed, generally within one working day. Written confirmation of the results will be provided to you, your physician, and your hospital. If time is pressing, you and your physician will be contacted by telephone, followed by the usual written confirmation. The Medical Service Advisory Review Unit's staff may recommend to your physician that your treatment be administered in an outpatient setting or that testing be done prior to admission.

Elective Admissions - Maternity
Maternity and related admissions are not entirely unexpected. Therefore, you must notify the Medical Service Advisory Review Unit prior to the time you expect to enter the hospital. You actually may have a scheduled date, if you and your physician have agreed on an elective cesarean section. In all cases, if the date that you or your dependent is actually admitted for maternity reasons is not firmly scheduled, and you have not given notice of the exact date, you, your physician, your family, or someone at the hospital must contact the Medical Service Advisory Review Unit within 48 hours of admission (72 hours if the confinement begins on a Saturday, Sunday, or legal holiday).

Emergency Admissions
Of course, in an emergency, no one expects you to call before you go into the hospital. Your health and well-being come first, and you should get whatever care your physician recommends. However, you, a family member involved in your health care, your physician, or someone at the hospital must call the plan administrator's Medical Service Advisory Review Unit at the number listed in the "Program Contacts" section at the beginning of this handbook as soon as possible within 48 hours of admission (72 hours if the confinement begins on a Saturday, Sunday, or legal holiday). Once you are hospitalized, your case is reviewed like any other hospitalization under the Pre-Admission Review process.

Continued Stay Review
During your hospital stay, the Medical Service Advisory Review Unit's staff will contact your physician at regular intervals to see if you are remaining in the hospital the expected length of time. If your physician decides that you need to stay in the hospital longer, the request for extension will be reviewed, based on the new information your physician will provide.

If the request for extension is approved, your doctor will be notified by phone. If your physician has not provided satisfactory additional proof of medical appropriateness to support the request for extension, your doctor will be called, and written confirmation will be sent to your physician and your home.

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Discharge Planning
Often there are alternatives to an extended hospital stay, and the plan provides coverage for many of these, including hospice, home health care, and extended care facilities. A Medical Service Advisory Review Unit professional will discuss appropriate options with your doctor so that, together, you and your physician can decide what is best for you.

If, in the course of Continued Stay Review or Discharge Planning, you decide to remain in the hospital beyond the number of days deemed reasonably necessary, payment for additional hospital days will be made only if your physician provides satisfactory additional proof of medical necessity.

Requesting Reconsideration from Managed Health Services
Normally, differences of opinion will be easily resolved between your physician and the Medical Advisor who initially reviews your case. However, if at any time in the review process you or your physician disagrees with the result of the review regarding the medical appropriateness of admission or length of stay, reconsideration of the review decision may be requested. Reconsideration is initiated by you or your physician calling or writing to the Claims Administrator. This request should be made in a reasonably prompt manner for timely reconsideration to be given.

If the Claims Administrator denies reconsideration, a written appeal may be made to the company as outlined in the *Administrative Information section.*

Medical Case Management
When you or your dependent suffers from a long-term or serious illness or injury, this program may be made available to help you explore alternate medical care choices that can offer more efficient use of benefits under the Plan.

In addition to the Managed Health Services Program, the plan offers a special program called Medical Case Management. The types of illnesses and injuries that may be considered appropriate for Medical Case Management include high risk newborns, severe stroke, certain cancers, serious burns or fractures, head injuries, AIDS, multiple sclerosis, and other grave diagnoses.

In the event that you or your dependent suffers from a long-term or serious illness or injury, this program may be made available to help you explore alternate medical care choices that may offer more efficient use of benefits under the plan. In some cases, the Case Management Consultant may offer an option that is an authorized exception to plan provisions. These alternatives will be reviewed with you and your physician. You have the right to accept or reject the proposed alternative course of treatment recommended by the Consultant. In no event, however, will the plan pay benefits for inpatient confinement deemed not medically appropriate through normal hospitalization review by the Managed Health Services Program.

Please remember that appropriate coinsurance percentages and deductibles will be applied in determining benefits. Benefits paid under Medical Case Management are included within and are not in addition to overall individual and family lifetime maximums.

Peoples Energy Corporation, through Medical Case Management and the Managed Health Services program is committed to helping you find the most appropriate care possible.

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Wellness Benefits
The Health Fund pays up to $250 for wellness benefits per covered person per year. In addition, the plan pays 100% of the cost of routine mammograms, PSA tests and colonoscopies without a deductible. This is in addition the money the Plan deposits in your fund at the start of each year.

Covered services include:

- Office visits for routine physical examinations
- Immunizations (travel-related immunizations not included)
- Routine gynecological examinations
- Routine Pap smears
- Routine mammograms
- Routine PSA tests
- Routine colonoscopies
- Routine labs, x-rays, and blood tests
- Well-child care for children under age six

Health Solutions℠
Employees enrolled in the PPO and Health Fund can take advantage of Health Solutions, a program that helps you take better control of your health. The program offers education on medication usage, early symptom identification, treatment options, diet, nutrition and healthy lifestyles as well as a health assessment and preventive screenings.

In addition you have 24/7 access to a toll-free support line staffed by experienced registered nurses for any questions and concerns you may have. There is no cost to you to use Health Solutions and all your personal health information is kept confidential.

Pregnancy
The medical plan covers pregnancy and childbirth in the same way as an illness or injury. A newborn must be enrolled within 60 days of birth.

Employees and covered dependents are eligible for pregnancy benefits under the medical plan. The plan covers the medical costs of pregnancy and childbirth (or other termination of pregnancy) in the same way it covers illness and injury.

All hospital inpatient confinements are subject to maternity Pre-Admission Review, Maternity Admission Notification, Continued Stay Review, and Discharge Planning provisions of the Managed Health Services Program.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The employee's new child may also be covered by the plan beginning on his or her date of birth. To secure coverage the employee must notify the company of the birth within 60

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days of the birth and complete Form 1414 (Medical Dependent Declaration Section), returning the signed form to Human Resources and subsequently furnishing a birth certificate at the earliest time. You must notify the company of your new family member whether or not you need to change your class of coverage. See *Eligibility and Participation* in the Overview of Health Care Benefits section for more information about dependent coverage.

Ambulance and Blood Services

Ambulance

The plan pays 80 percent (in-network and out-of-network) of the cost of professional ambulance service - ground or air transportation - to transport a sick or injured person to and from the hospital after the annual deductible requirement is met.

Blood

The plan pays 80 percent of charges for blood or blood plasmas and for the administration of blood, under certain circumstances.

Note: Company employees and all annuitants receive blood free of cost through the Life Source-sponsored Blood Replacement Program, which is made possible through regular blood donations by employees. Blood administration expenses are covered by the plan, as stated above.

Home Health Care

If certain care usually given in a hospital is given at home by a qualified agency under an approved plan, the plan pays 90 percent in-network/70 percent outof-network subject to R&C - after the fund has been spent and the in-network annual deductible requirement is met.

In certain limited circumstances, treatment that is normally given in a hospital - for example, certain kinds of therapy and some convalescent care — can be administered at home. The plan covers this care, called "home health care," if it meets these three conditions:

- Care is given by a qualified home health care service or by a hospital authorized to give home health care services,
- Care is administered under a predetermined plan approved by the patient's doctor, and
- The doctor certifies that in the absence of a home health care program, the patient would have to be hospitalized.

If these conditions are met and the annual in-network deductible requirement has been satisfied, the plan pays 90 percent in-network/70 percent out-of-network subject to R&C.

Covered Charges:

- Part-time nursing care under the supervision of a registered nurse;
- Personal care given by the home health care service;
- Physical, occupational, and speech therapy (subject to $1,000 maximum limit per each therapy per year); and

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- Medical supplies, drugs, medicine and laboratory services that would have been covered had the patient been hospitalized, if they are ordered by a doctor.

Home health care benefits will not be paid for transportation services, costs that are eligible for Medicare, or custodial care (that is, care primarily for a person's physical needs).

Contact the plan's Medical Service Advisory Review Unit (see "Program Contacts" at the front of this handbook) for more detailed information before arranging home health care.

Extended Care
Coverage is provided for skilled nursing care at an extended care facility following a hospital stay. Certain conditions apply.

When skilled nursing care is required following treatment at a hospital, an "extended care facility" may be able to provide it at the most reasonable cost. The plan covers such charges if these conditions are met:

- Confinement must be in a qualified extended care facility that is not primarily engaged in providing custodial care,
- Confinement must begin by means of a direct transfer from a hospital in which the individual was confined for at least three days, and
- Confinement must be for the same condition that caused the individual to be hospitalized.

Charges for the use of an extended care facility are paid by the plan at 90 percent in-network/70 percent out-of-network (union) or 80 percent innetwork/60 percent out-of-network (nonunion) after the deductible. Following is a list of the kind of services that are covered:

- Room and board (limited to 60 days per person per year)
- Nursing care (except private duty), up to $1,000 per person, per month (nonunion)
- Physical, occupational, and speech therapies (subject to $1,000 maximum limit per therapy per year) (nonunion)
- Medical social services under the direction of a physician
- Biologicals, supplies, appliances, and equipment
- Diagnostic and therapeutic services
- Other necessary services generally provided to patients by extended care facilities

Contact the plan administrator's Medical Service Advisory Review Unit for more detailed information before arranging a stay at an extended care facility.

Hospice Care
Hospice care is specialized care for patients known to be terminally ill. This kind of care will be covered for a six-month period, when a physician certifies that a patient is

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terminally ill. The benefit may be extended for further periods once the doctor certifies the condition continues.

Inpatient Hospice Care
Inpatient care at a hospice or arranged for by a hospice will be paid at 90 percent in-network/80 percent out-of-network after deductible. This can include one period of "respite care" per calendar month, where an individual who has been receiving *hospice home care* goes to the *Hospice*, to give family members a break from the strain of providing health care to a terminally ill loved one. Confinements for custodial care will not be covered under the plan. Contact your Claims Administrator claims approver for more detailed information before arranging for Hospice care.

Hospice Home Care Services
This plan will cover services and supplies used in the patient's home, if they are provided or arranged for by a hospice as part of a written hospice care plan. Coverage is at 90 percent in-network/70 percent out-of network after the fund is exhausted and the deductible is met, and there is a lifetime maximum of $12,500. Following is a list of the kinds of services and supplies covered.

- A doctor's care
- Part-time nursing care
- Physical, respiratory, occupational, and speech therapies (subject to $1,000 maximum limit per therapy per year) (nonunion)
- Counseling by a registered dietician
- Part-time services of a trained home health aide
- Laboratory services, drugs, medication, medical supplies, and appliances prescribed by a physician
- Transportation of the patient to the place where hospice home care will be received

Vision Care
The plan pays 90 percent (union) and 80 percent (nonunion) per person per year - up to $200 - for the costs of routine eye exams, glasses and contact lenses. There is no deductible for vision care benefits. You can visit the vision care provider of your choice.

To receive benefits, you or your provider must file a claim with your medical plan administrator. If you submit the claim, you will be reimbursed for your costs, up to the $200 maximum. Use the standard claim form available from your plan administrator.

Mental Health and Substance Abuse, Including Alcohol

The plan generally pays a major portion of the medical expense for treatment of mental health and substance abuse, including alcohol. Hospital charges and doctor's fees for inpatient and for outpatient care are included. However, strict limits are set on the number of days that will be covered.

For a referral to an in-network provider in your area, call the plan administrator listed in the "Program Contacts" section at the front of the book.

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Inpatient Care
The plan pays in-network charges at 90 percent in-network and 50 percent out-of-network, with no deductible, for the treatment of mental health and substance abuse, including alcohol. There is a $1,000 out-of-pocket maximum per person per calendar year. Benefits are payable for no more than 30 days of confinement in a calendar year for each covered person, except for treatment of substance abuse, which is limited to only a second confinement in a lifetime after at least 5 years have passed after the first confinement.

Outpatient Care
In-network physician charges for outpatient treatment of mental health and substance abuse, including alcohol, are covered at 100 percent of reasonable and customary charges subject to a $15 copay per visit. Out-of-network treatment is covered at 50 percent of reasonable and customary charges. There is a limit of 30 visits in a calendar year for each covered person.

Lifetime Maximum Benefits
For each individual, benefits paid for treatment of mental health and substance abuse, including alcohol, are included in the overall individual lifetime maximum, subject only to a 60-day inpatient lifetime maximum for each covered person.

Psychiatric and Substance Abuse Case Review
Psychiatric and Substance Abuse Case Review is provided by the administrator of the mental health and substance abuse benefits provided under the Medical and Dental Plan. The purpose of Psychiatric and Substance Abuse Case Review is to help you make the most of your benefits for inpatient treatment of mental health and substance abuse, including alcohol. Related cases are reviewed by a Psychiatric and Substance Abuse Case Review Specialist.

Hospital confinements for mental health and substance abuse, including alcohol, are subject to all elements of the Managed Health Services Program review process, including penalties for noncompliance described under that section. This means that, in all cases, medical appropriateness must be effectively demonstrated for inpatient confinement to make certain that you or your dependent receives the maximum level of benefits for which you are eligible under the plan.

If you or a dependent is hospitalized for treatment of mental health and/or substance abuse, including alcohol, notify the plan administrator's intake counselor, at the number listed in the *Program Contacts* section at the beginning of this handbook. Intake counselors are available 24 hours, seven days a week.

A Psychiatric and Substance Abuse Case Review Specialist will review the case for necessity of admission and appropriate length of stay. During the course of confinement, the Specialist may recommend alternative medical care choices that offer more efficient use of benefits provided under the plan. In some cases, these alternatives may involve authorized exceptions to plan provisions. These will be reviewed with you and your physician. You have the right to accept or reject the proposed alternate course of treatment recommended by the Specialist. In no event, however, will the plan pay benefits for inpatient confinement deemed not medically appropriate through normal hospitalization review by the Specialist.

Benefits paid under Psychiatric and Substance Abuse Case Review are included in the lifetime maximum benefit for mental health and substance abuse available as part of the overall individual lifetime maximum.

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HealthFund Medical Coverage Exclusions
The HealthFund does not cover the following:

- Charges for medical services and supplies that are in excess of the Schedule of Maximum Allowances established by the Plan or that are in excess of reasonable and customary charges
- Charges for medical services and supplies that are not medically necessary (except for mammogram screening, vision and wellness benefits)
- Charges not considered appropriate under the administrative practices commonly adhered to by the Claims Administrators
- Illness or injury that is related to work
- Treatment or hospitalization that is not approved by a qualified doctor
- Cosmetic surgery unless it is made necessary by accidental injury that occurs while you are insured
- Dental treatment other than the treatment for accidental bodily injury to sound natural teeth
- Hearing aids — or the examination to prescribe them
- Care that is primarily custodial in nature, such as extended care or nursing home care
- Illness or injury caused by war, by self-inflicted injury, or by participation in a riot or commission of a felony
- Services provided by any medical practitioner who is related to the patient or lives in the patient's household
- Medical services or supplies that are furnished or paid for by the government or provided through government programs, or for which the patient is under no legal obligation to pay

Note: The above is a partial list of exclusions; others may apply.

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Dental Coverage

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Dental Coverage

The two dental options: Dental PPO and Dental PPO Plus pay for preventive dental care, a wide variety of basic and major dental services, and orthodontia services for dependent children under age 19.

Dental PPO Plus Option

With PPO Plus, dental coverage is provided through a traditional indemnity dental plan. The plan pays reasonable and customary charges for certain dental expenses as follows:

- 90 percent of covered charges for preventive care (no deductible requirement)
- 80 percent of covered charges for basic care after meeting a separate annual $50 per person or $150 per family deductible
- 50 percent of covered charges for major care also subject to the deductible
- 50 percent of covered charges for orthodontia for dependent children under age 19 (no deductible requirement)

If you stay in-network, you benefit from lower, contracted, rates.

The maximum annual reimbursement for covered basic, preventive and major services is $1,750 per person. Orthodontic work has a separate lifetime maximum of $2,000 per person.

Dental PPO Option

With the PPO, you pay a lower premium, have no deductible and routine preventive checkups are covered in full. In exchange for the lower plan costs and richer benefits, you receive a lower level of coverage on out of network services.

Dental Coverage Provisions

As with the medical deductible, dental expenses that occur in October, November, and December - and are applicable to the deductible - also count toward satisfaction of the dental deductible in the following calendar year.

The plan will reimburse no more than $1,750 of dental care expenses for any covered individual in a given year. That limit applies to preventive care, basic care, and major care services, combined. Reimbursements for orthodontic work for any covered child have a *separate lifetime maximum* of $2,000.

For a complete list of items covered by the plan see *Covered Dental Procedures* in this section.

In the event dental charges are expected to exceed $250, the plan provides a pre-treatment review feature to help you determine your benefit coverage before services are rendered. (See *Other Dental Coverage Provisions* in this section for a complete explanation of pre-treatment review and its related provisions.)

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To help you determine your benefit coverage and provide cost-effective treatment, the plan also includes the following features:

Pre-Treatment Estimate
In the event charges for dental services are expected to exceed $250, you should request a benefit pre-estimate. To do this, have your dentist complete the dental claim form by: 1) itemizing the dental services recommended, and 2) showing the charge for each dental service. The completed claim form should be submitted to the Claims Administrator. The pre-treatment estimate is designed to eliminate any misunderstanding you might have with respect to your coverage before you begin your dental treatment.

Alternate Course of Treatment
The plan's alternate course of treatment provision limits covered dental expenses to the least expensive, professionally adequate procedure or course of treatment which, as determined by the Claims Administrator, will produce a professionally adequate result.

Patient-Dentist Relationship
The pre-treatment review and alternate course of treatment provisions are not intended to interfere in the patient-dentist relationship. They are a means of informing you, in advance, of the services covered and benefits payable under the plan. If you and your dentist select a more costly and elaborate treatment program, you will have to pay the additional cost.

Covered Dental Procedures
Any procedure not listed is excluded unless the treatment provided is for a condition for which one or more of the listed procedures would be appropriate under customary dental practice. In that event, the maximum covered charge will be the amount allowable for the least expensive appropriate listed procedures.

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Preventive Care Services

For Dental PPO Plus: 90 %; no deductible
For Dental PPO: 100%; no deductible in-network /70% of Maximum allowance out-of network

- Oral examinations - initial and periodic oral exam.
- Prophylaxis - cleaning and scaling of teeth, limited to treatment twice per calendar year.
- Dental x-rays - supplementary bitewing x-rays are limited to twice per calendar year; periapical x-rays, single films, initial and additional are limited to 12 per calendar year. To be considered under preventive care, the x-rays listed must be furnished at the same time as other preventive care services. In addition, the timing of services must comply with the stated frequency for other preventive care services.
- Fluorides - topical application of stannous fluoride, limited to one treatment per 12 consecutive months for covered persons under 18.
- Space maintainers, limited to the initial appliance - including installation, fitting and all adjustments within six months of installation, and limited to covered persons under age 16, and excluding all repairs to such.
- Removable appliance therapy or fixed or cemented appliance therapy to control harmful habits, limited to the initial appliance - including installation, fitting and all adjustments within six months of installation, and limited to covered persons under age 16.
- Pit and fissure sealants on permanent molars for persons under age 14, but not more than one in any period of 48 months.

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Basic services

Dental PPO Plus: 80%; after deductible
Dental PPO: 80% of maximum allowance in-network /60% of maximum allowance out-of network

Diagnostic and therapeutic services

- Dental x-rays - entire denture series, including full mouth, panoramic, occlusal and intra-oral views, limited to once every 36 consecutive months; other x-rays as required for diagnosis when not associated with dental preventive care services and supplies.

- Tests and laboratory examinations - limited to diagnostic casts (study models) and biopsy and examination of oral tissue.

- Oral surgery, including local anesthesia and customary postoperative treatment furnished in connection with oral surgery.

  - Extraction of one or more teeth, including simple, surgical, and impacted removal.

  - Alveolectomy, alveoplasty, stomatoplasty, frenulectomy, excision of pericoronal gingiva, removal of palatal or mandibular tori (exostosis), excision of hyperplastic tissue and oral tissue for biopsy, excision of a tumor or cyst or incision and drainage of an abscess or cyst, tooth replantation.

  - Other oral surgical procedures, including removal of foreign body, closure of oral and salivary fistula, sequestrectomy, maxillary, sinusotomy, suture of soft tissue injury, sialolithotomy, and closure or dilation of salivary duct.

- Periodontics - treatment of periodontal diseases of the gums and tissues of the mouth, limited to gingivectomy, gingival curettage, and osseous surgery (post-surgical visits included), pedicle soft tissue grafts, occlusal adjustments related to periodontal problems, periodontal scaling, and prophylaxis.

- Endodontics - pulp capping, vital pulpotomy and treatment of disease of the nonvital dental pulp, including apicoectomy and medicated paste, and traditional root canal therapy and remineralization.

- Following services and supplies:

  - Emergency palliative treatment.

  - General anesthetics and the administration thereof, when performed in conjunction with surgical procedures only.

  - Antibiotic drug injection by attending dentist.

  - Prescription drugs prescribed by attending dentist.

  - Visits and professional consultation by other than practitioner providing treatment.

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– Professional dental visits after hours.

Restorative services and supplies

- Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations, including pin retention and stainless steel crowns to restore diseased or accidentally broken teeth.
- Recementing of crowns, inlays and bridges.
- Relining of dentures more than six months after the installation of initial or replacement denture, and limited to once per 12-month period.
- Duplication (Rebasing) of dentures more than six months after installation of initial or replacement denture, and limited to once per 36-month period.
- Repair of full and partial denture, acrylic.
- Adjustments to dentures more than six months after installation, or if performed by other than dentist providing appliance.
- Tissue conditioning - more than six months after installation of appliance, and limited to two treatments per arch, once per 12-month period.

Major services

Dental PPO Plus: 50 %; after deductible
Dental PPO: 50 % in network; 50 % out of network

Restorative services

- Inlays, onlays, or acrylic, porcelain, or gold crown restorations, cast post and cores, to restore diseased or accidentally broken teeth.
- Replacement of an existing inlay, onlay, or acrylic, porcelain, or gold crown restoration as described above, but if such appliance was installed while covered under this plan, at least five years must have elapsed prior to its replacement or such replacement must be required as result of accidental bodily injury sustained while covered under this plan.
- Repair of crowns and bridges.
- Repair of partial dentures, metal.

Prosthodontic services and supplies

- Initial installation, including adjustments and relines within six months after installation of removable permanent partial or complete permanent dentures, but only if the denture includes replacement of a natural tooth that is extracted while the individual was covered under this plan.

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- Initial installation of bridgework, including pontics, inlays, and crowns as abutments, but only if the bridge includes replacement of a natural tooth that is extracted while the individual was covered under this plan.

- Replacement of an existing removable partial or complete denture by a new removable denture. Addition of teeth to an existing removable partial denture.

- These services are covered only if satisfactory evidence is presented that the replacement or addition of teeth is required to replace one or more teeth extracted while the individual was covered under this plan, and:

  - The replacement or addition of teeth is required to replace one or more teeth extracted after the existing removable partial denture was installed;

  - If such denture was installed while the individual was covered under this plan, 36 months have elapsed prior to its replacement; or

  - If necessitated by accidental bodily injury.

- Replacement of an existing bridge by a new bridge, or addition of teeth to an existing bridge. These services are covered only if satisfactory evidence is presented that the replacement or addition of teeth is required to replace one or more teeth extracted while the individual was covered under this plan, and:

  - The replacement or addition of teeth is required to replace one or moreteeth extracted after the existing bridge was installed;

  - If such bridge was installed while the individual was covered under this plan, five years have elapsed prior to its replacement; or

  - If necessitated by accidental bodily injury.

- Stayplate bases - limited to front teeth only.

- Simple stress breakers.

- Occlusal guards related to periodontal surgery.

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Orthodontia services:
These services are covered only for dependent children under age 19. This means the plan pays benefits up to the19th birthday only - benefits will cease at that time even if treatment continues.

Coverage is limited to a lifetime maximum of $2,000 for the following:

- Cephalometric film.
- Orthodontic appliances, including impressions, installation, and all adjustments within six months of installation, for:
  - Minor treatment for tooth guidance; and
  - Interceptive orthodontic treatment.
- Comprehensive orthodontic treatment of transitional or permanent detention, including:
  - Initial placement of orthodontic appliance; and
  - Subsequent active orthodontic treatment.

With respect to benefit payments related to initial placement of an orthodontic appliance, charges for services provided shall be deemed a covered dental charge only to the extent of 50 percent of the reasonable and customary charge for the initial banding fee.

Dental Coverage Exclusions
The dental plan does *not* cover:

- Orthodontia, except for services listed under Orthodontic Services of Covered Dental Procedures that are provided to dependent children under age 19
- Charges for dental services or supplies that are in excess of what is reasonable and customary or are not a medical or dental necessity. If the charges are not considered appropriate under the administrative practices commonly adhered to by the Claims Administrator
- Dental care and treatment necessitated by accidental bodily injury to sound natural teeth (See Summary in this section.)
- Illness or injury caused by war, by self-inflicted injury, or by participation in a riot or commission of a felony
- Illness or injury that is related to work
- Service furnished for cosmetic purposes
- Replacement of lost or stolen appliance
- Services for initial installation of a partial or full removable denture or fixed bridgework, unless such includes replacement of a natural tooth (or teeth) extracted while covered under the plan

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- For appliances, restoration, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting or replacing tooth structure lost as a result of abrasion, or attrition or treatment of disturbances of the temporomandibular joint

- Services not furnished by a dentist or dental hygienist under the supervision of a dentist

- Services furnished by any dental practitioner who is related to the patient or lives in the patient's household

- Services or supplies that are furnished or paid for by the government or provided through government programs, or for which the patient is under no legal obligation to pay

Note: The above is a partial list of exclusions; others may apply.

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Health Maintenance Organization

(HMO)

EXHIBIT 4

Important Information

The following pages give you basic information about the health maintenance organization (HMO) options. A complete description of the benefits provided by each HMO is included in the HMO Certificate or HMO Subscriber Agreement. Should there be any disagreement between the description in your handbook and the HMO Certificate or Agreement, the HMO Certificate or Agreement will govern.

The HMO options are sponsored by Peoples Energy Corporation and its companies. For simplicity, the term "company" in this description means all the sponsoring companies as a group.

- The HMOs are offered as part of a welfare benefit plan and provide benefits to help with the medical costs of nonoccupational illness and injury. While the plan year for these benefits is October 1 through September 30 for IRS purposes, you enroll in benefits for the calendar year.
- The company expects to continue its HMO options indefinitely, but reserves the right to change or terminate an HMO option or any agreement with individual HMOs at any time.
- This plan is subject to certain provisions of the Employee Retirement Income Security Act (ERISA).
- Participants covered: Subscribing employees and retirees of sponsoring Peoples Energy companies and their eligible dependents.

If you communicate to the government about this plan, identify it with these numbers:

Employer I.D. number: 36-2642766
Plan number: 501

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The HMO Option
Most employees will have a choice of medical coverage among the PPO option, the Health Fund option (described under the Medical and Dental Plan section of this handbook) or one or more HMO.

If you enroll in an HMO, your dental coverage is provided under the dental portion of the Medical and Dental Plan, except for care and treatment necessitated by accidental injury to sound natural teeth. Your HMO would provide those services under such circumstances.

All benefits, limitations, and exclusions for the HMO option are listed in the respective member brochures and contracts.

Upon request, the HMO plan will supply you with written materials concerning the following; requests for the following may also be made to the Human Resources Phone Line.

- The nature of services provided to members;
- Conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the plan) and the procedures to be followed in obtaining such services; and
- The circumstances under which services may be denied and the procedures available for the review of claims for services that are denied in whole or in part.

If you have questions concerning HMO coverage, please contact your HMO's member services directly.

Basic Description of an HMO
An HMO is an alternative form of health care. When you belong to an HMO, you receive most - if not all - of your health care services from the doctors, hospitals, and other medical providers associated with the HMO. Contractual arrangements with the providers allow the HMOs to control how much they will be paid, how the quality of their service will be assessed, and how the administrative details and delivery of health care services will work.

HMOs emphasize preventive medicine. Routine health care, including physicals, immunization and well-baby care, is covered. By encouraging you and your family to seek outpatient care on a regular basis, when the first symptoms are noticed, HMOs hope to treat your medical problems before they become serious. The goal of HMOs is to control health care costs by treating patients in the early stages of illness and encouraging physicians to perform their services on an outpatient basis. This usually serves to reduce hospital costs and often helps HMOs and their members save money.

Routine medical care must be provided through the HMO facility you select. When you join an HMO, you choose a primary care physician (PCP), who acts as a medical care manager, coordinating all your health care services. Any visits to specialists, or emergency rooms within the HMO service area, must be approved by your primary care physician before you receive any treatment.

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Even if an emergency occurs outside of the service area, you must contact your primary care physician and receive approval for the treatment within 48 hours of the emergency. Any services provided without authorization may not be covered by the HMO.

Currently, a number of HMOs with various facility locations are available to employees and to retirees under age 65. Each HMO defines a "service area" which is usually within about 30 minutes driving distance from all the HMO medical centers, hospitals, and doctors. A major consideration in selecting an HMO is the proximity of its facilities to your residence. Generally, your eligibility to join a specific facility is determined by your residential zip code.

Advantages of an HMO

- Organized health care delivery, an emphasis on routine care, and being able to budget for costs ahead of time, are among the advantages of an HMO.
- Other advantages of belonging to an HMO may include the following:
- Generally, you are assured of having a physician when you need one. The HMO helps you establish a relationship with one of its physicians as soon as you enroll. You select a doctor who becomes your primary care physician (PCP).
- HMOs emphasize preventive medicine. HMOs provide annual physicals, well-baby care and immunizations to reduce the need for later, more serious medical treatment.
- An HMO is an organized system of health care delivery. The HMO arranges for doctors, hospitals, X-ray technicians - all the services you and your family will need.
- HMO coverage is easy to understand and deal with. Normally there are no claim forms for you to complete and no waiting for repayment.
- As a member of an HMO, you can effectively budget your total health care expenditures. Your monthly contributions for HMO services are fixed at the beginning of each year. The only additional expenses you may incur are small copayments for certain services.

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Disadvantages of an HMO

Disadvantages of belonging to an HMO may include ending a relationship with your family doctor, limited access to health care providers, and inconvenient location of medical services, among others, as explained below.

- You may have a rapport with your family doctor that is not in your best interest to disturb. When you join an HMO, you end that relationship - unless your current family doctor is affiliated with the HMO. The HMO will not pay for treatment from doctors outside the HMO network.

- HMOs control your access to health care through your primary care physician. If you decide to seek specialist care or go to an emergency room without a referral from your primary care doctor, or if you do not receive approval for out-of-town emergency treatments within 48 hours of the emergency, the HMO may not cover the charges.

- The HMO option may not be appropriate if you or your family members, including college students, live outside of your HMO service area for a portion of the year. Outside of that area, service will be provided only on a true emergency basis, as defined by your HMO.

- Not all facilities may offer all medical specialties and not all specialties may be available during all facility hours. Facility hours also may vary.

- The location of HMO facilities may be inconvenient. Each HMO has a "service area" within which you should reside. The idea is to limit the amount of travel time needed to receive health care to 30 minutes. If you now travel a much shorter period of time to reach your providers, going to a distant HMO location may not be practical.

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Participation in an HMO

Enrolling in an HMO
You may elect to join an HMO, provided you reside in the HMO's designated service area, when you become employed by the company or, afterwards, during the annual open enrollment period held in the fall of each year. Open enrollment is the period during which employees can move between the various health plans being offered. Information about the HMO and PPO options is provided through the Health Care Benefit Comparison Chart, which is issued annually at open enrollment time and should be kept in your handbook. To request HMO coverage, you must complete Form 1414 and the HMO application.

If you move out of your HMO's service area, or if your facility closes and there is no alternative facility within the same HMO available to you, you may immediately enroll in another available HMO or the PPO option.

If you later re-enroll in the PPO option, the previous amounts charged against your individual lifetime maximum coverage amount will again apply.

Paying for HMO Coverage
Employees enrolled in an HMO pay a portion of the premium cost, with the company paying the major share. Your health care expenses are generally limited to your premium contributions and any applicable copayments required for some care. The HMO Plus plan features higher premiums, but lower copays ($15 copayment for most outpatient services) when care is required. The HMO features lower premiums, but higher copays for most services when you use them.

Your medical and dental coverage contributions are deducted from your paycheck. The amount of your contributions depends on whether you choose employee or retiree only or another level of coverage. Contribution amounts are communicated annually during open enrollment. You will be advised whenever a change in costs affects your contributions.

Pre-Tax Payment Opportunity
For active employees, premium contributions can be paid on a pre-tax or on an after-tax basis. Under the pre-tax contribution program, your monthly premium contributions are deducted from your regular pay before federal, state and Social Security taxes are taken - the result is that taxes are reduced, and take-home pay is correspondingly increased. By law, the pre-tax contribution is available only to active employees. Employees on layoff status and retirees are not eligible to participate. The opportunity to enroll in the pretax contribution program is limited to once a year and, generally, your participation remains in effect for the entire year. New employees can enroll in the program at the time they are hired.

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Claims Procedure
If a claim is denied either in whole or in part you have the right under state law to have the denied claim independently reviewed. The plan participant may submit a written request for reconsideration, as outlined in the HMO Certificate or Subscriber Agreement, which you received at the time of your HMO enrollment. Such request should be accompanied by whatever documents or records may be available to support the claim. If you are not satisfied with the response of the HMO claim review, you may then submit your complaint through the HMO grievance procedures. If you do not receive satisfaction from your HMO, a formal written claim for review may be made to the company as outlined in the *Administrative Information section.*

HMO Coverage After Retirement
If you have completed 10 years of continuous service after age 40, you may either continue HMO coverage or change your coverage to the PPO option, provided you are not eligible for Medicare. Coverage under an HMO ends when you become Medicare-eligible on the basis of age or early disability. You would then be eligible for the Medicare Supplement Plan. See Eligibility and Participation in both the Medicare and Medicare Supplement and Health Care Benefits sections of this handbook for enrollment information. Any change in health care eligibility must immediately be reported to the company.

When your dependent spouse becomes eligible for Medicare, coverage under the HMO ceases for him or her and coverage becomes available through the Medicare Supplement Plan. If at that time you, the retiree, are still eligible for HMO coverage, you may continue under your current HMO. When you, the retiree, become Medicare-eligible, coverage under the HMO will cease for you.

Dental Benefits
In general, your dental coverage is provided under the dental portion of the Medical and Dental Plan. However, dental care and treatment necessitated by accidental injury to sound natural teeth is provided by the HMO, subject to its limitations.

Other HMO Provisions
Just as medical benefits may vary from HMO to HMO, so may administrative provisions. You should refer to your HMO Certificate or Subscriber Agreement for specific provisions. Because the HMO option is part of the Medical and Dental Plan, the administrative provisions of the Medical and Dental Plan may also apply to your coverage. For the most part, you may refer to the following information under the Health Care Benefits and Medical and Dental Plan sections:

- Eligibility and Participation
- Fraudulent Claims
- Coordination with Other Group Medical Plans
- When Medical and Dental Coverage Ends
- COBRA Continuation Coverage
- Dependent Coverage When You Die While Employed
- Medical Coverage After Retirement
- Administrative Information

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section 15

Administrative Information

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Plan Administration

If you have questions or comments about certain benefit plans that are subject to the Employee Retirement Income Security Act (ERISA), you should contact the plan administrator. Legal process should be served on the agent for legal process. Your benefit plans are sponsored by Peoples Energy Corporation and its companies.

Plan Administrator
The plan administrator is responsible for certain benefit plans that are subject to the Employee Retirement Income Security Act (ERISA). The plan administrator interprets provisions of these plans and sees that the plans run smoothly in other ways. The plan administrator has the discretionary authority to determine who is eligible for benefits and the amount of any benefit payable under any of the plans.

The plan administrator is:

Retirement and Benefit Plans Committee
c/o Peoples Energy Corporation
130 East Randolph Drive
Chicago, IL 60601
Telephone: (312) 240-4000

Agent for Legal Process
Legal matters about the benefit plans that are subject to ERISA should be addressed to:

Mr. P. Kauffman
Assistant General Counsel and Secretary
c/o Peoples Energy Corporation
130 East Randolph Drive
Chicago, IL 60601
Telephone: (312) 240-4000

Also, legal process may be served on the plan administrator and on the trustee of those plans that have a plan trustee.

Your benefit plans are sponsored by the following companies:

- Peoples Energy Corporation, 130 East Randolph Drive, Chicago, IL 60601
- The Peoples Gas Light and Coke Company, 130 East Randolph Drive, Chicago, IL 60601
- North Shore Gas Company, 3001 Grand Avenue, Waukegan, IL 60085
- Peoples Energy Resources, 130 East Randolph Drive, Chicago, IL 60601
- Peoples Energy Production, 909 Fannin St., Ste. 1300, Houston, TX 77010
- Peoples Energy Services, 205 N. Michigan Ave., Ste. 4216, Chicago, IL 60601
  (Group insurance, flexible spending accounts and Capital Accumulation Plan only)

Plans Subject to Collective Bargaining Agreement
Participation in some benefit plans by some employees is determined under a collective bargaining agreement. Copies of the collective bargaining agreements that provide for this participation are available for examination at the plan administrator's office (i.e., in Human Resources). Also, you may obtain your own copies by submitting a written request to the plan administrator and paying a reasonable charge.

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Your Rights Under the Employee Retirement Income Security Act of 19 74 (ERISA)

As a participant in Peoples Energy's benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- You are entitled to examine-at no charge-at the plan administrator's office and at other specified locations, such as worksites and union halls, during regular business hours, all documents governing the plans, including insurance contracts, administrative agreements and collective bargaining agreements. You may also examine at no charge a copy of the latest annual reports (Form 5500 Series) filed by the plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- You may obtain, upon written request to the plan administrator, copies of documents governing the operation of the plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual reports (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

- You are entitled to receive-at no charge-a copy of the plans' annual financial reports. The plan administrator is required by law to furnish each participant with a copy of these summary annual reports.

- You may obtain-at no charge-a statement telling you whether you have a right to receive a pension or retirement benefit at normal retirement age and, if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. You must request this statement in writing. The plan administrator is not required to provide it more than once every 12 months.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, your spouse or your dependents if you or your dependent(s) lose coverage under the plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review your summary plan description and the documents governing the plans on the COBRA continuation coverage rights rules.

Your group health plan or health insurance issuer should provide you with a certificate of creditable coverage—at no charge—when:

- You lose coverage under the plan,
- You become entitled to elect COBRA continuation coverage, and/or
- Your COBRA continuation coverage ends.

If you do not receive the certificate of creditable coverage, you must request the certificate within 24 months of losing coverage.

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Having creditable coverage from another plan may reduce or eliminate any exclusionary periods of coverage for pre-existing conditions under your group health plan. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after you enroll in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called *fiduciaries* of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your pension or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a pension or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, you can take steps to enforce the above rights. For example, you can file suit in a federal court if you:

- Request a copy of plan documents or the latest annual report from the plan and do not receive it within 30 days. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

- Have a claim for benefits that is denied or ignored, in whole or in part. (You may also file a claim in state court.)

- Disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order.

- Are discriminated against for asserting your rights. (You may also seek assistance from the U.S. Department of Labor.)

You may also seek assistance from the U.S. Department of Labor or file suit in a federal court if it should happen that plan fiduciaries misuse the plan's money.

The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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Assistance with Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact:

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or

- The Division of Technical Assistance and Inquiries Employee Benefits Security Administration U.S. Department of Labor
  200 Constitution Avenue, N.W.
  Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Denied Claims

If you file a claim for benefits (see each section for instructions on filing claims) and your claim is denied, the Claims Administrator must send you a written explanation, including:

- The specific reasons the claim was denied. You may request that any document or record that was relied upon to reach the decision to deny benefits be provided at no charge;

- References to the plan provisions upon which the denial is based;

- A description of additional information, if any, that you need to provide to complete or support the claim and an explanation of why the additional information is necessary; and

- An explanation of the appeal procedure under the plan, including your right to bring a claim in federal court.

Filing Claims and Appeals
If a claim for benefits is denied, you may have it reviewed. There are specific steps you must follow. They are summarized below.

- For most medical benefits, the initial claim must be made in writing to the provider. Other initial claims may be made to Human Resources. If some or all of your initial claim is going to be denied, you will be notified of that fact in writing. In addition, you will be given a description of the claim review process and told why benefits are being denied. Also, you will be told what additional information is needed from you to strengthen your claim and why that information is necessary.

- The table below summarizes the claims review and appeal procedure for medical benefits.

- For all other initial claims, generally, you will be informed within 90 days (45 days for disability claims) of the date your claim was received if benefits are to be denied. However, the company is allowed to notify you within those first 90 (or 45)

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days that an additional 90 days (or up to 60 days for disability claims) is required to consider your claim. If additional time is required, the company will let you know why. You will have 60 days (180 days for disability claims) to appeal the decision, and will be notified within 60-120 days (45-90 for disability claims) of the decision on review.

Medical Claims Review and Appeal Procedures

Type of Claim	First Appeal	Second Appeal	Third Appeal
PPO or Aetna HealthFund Urgent Care Claims	Claims Administrator*	Human Resources You will receive oral notice of the decision within 72 hours, written notice within 3 days if more information is requested.	Retirement and Benefit Plans Committee (i.e., the Medical/Health Care Professional Consultant) You may submit your request for review orally or in writing. You will receive an oral or written notice of the decision within 72 hours.
PPO or Aetna HealthFund Pre-Service Claims	Claims Administrator*	Human Resources You will receive notice of the decision within 15 days, which may be extended for up to 15 days.	Retirement and Benefits Plans Committee (i.e., the Medical/Health Care Professional Consultant) You must submit your written request for an appeal within 180 days after being notified that your claim was denied by Human Resources. You will receive written notice of the decision within 30 days.
PPO or Aetna HealthFund Post-Service Claims	Claims Administrator*	Human Resources You will receive oral notice of the decision within 30 days, which may be extended for up to 15 days.	Retirement and Benefits Plans Committee (i.e., the Medical/Health Care Professional Consultant) You must submit your written request for an appeal within 180 days after being notified that your claim was denied by Human Resources. You will receive written notice of the decision within 60 days.

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Medical Claims Review and Appeal Procedures (con't.)

Type of Claim	First Appeal	Second Appeal	Third Appeal
PPO or Aetna HealthFund Concurrent Care Decisions This relates to an ongoing course of treatment and an Adverse Benefit Determination**. *Note: Any Adverse Benefit determination by the plan must be communicated to Human Resources prior to reduction or termination of benefit to allow for an appeal.*	Human Resources You will receive notice as follows: Urgent Care: within 24 hours Pre-Service Claims: 15 days Post-Service Claims: 30 days	Retirement and Benefit Plans Committee You will receive notice of the decision as follows: Urgent Care: within 72 hours Pre-Service Claims: 30 days Post-Service Claims: 60 days	
HMO Claims	HMO Administrator Submit a written request for reconsideration to the HMO in the manner outlined in the relevant HMO Certificate or Subscriber Agreement received at the time of enrollment.	Grievance procedures Outlined by the HMO.	Illinois Department of Insurance

*The Claims Administrator is BlueCross BlueShield of Illinois.

**Any Adverse Benefit Determination notification will include the following statement:
You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency.

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Company Service Provisions

Eligibility to participate in certain plans and the amount and duration of certain benefits depends on your accumulated company service, employment status and, in certain cases, your date of employment. The company service provisions described here apply to all benefits described in the handbook except the Capital Accumulation/Thrift Plan, Employee Stock Ownership Plan, Retirement Plan, and Service Annuity System (the pension plan for union employees). Service provisions for these plans are described in the plans' respective sections of this handbook.

For purposes of all other benefit plans, your company service begins on your first day of employment and grows until the date your employment ends. However, if your period of employment is not continuous - due to a temporary separation from the payroll (layoff, leave of absence) or a full separation from the payroll (resignation or release) followed by re-employment - your company service credit may be affected as follows:

Before May 1, 1981 Layoff

- Your service continued to accumulate during the first six months of any layoff, but no service credit was given for any additional months of such a layoff.
- Approved personal leave of absence
- Your service credit continued to accumulate during the first three months of any approved leave of absence, but no credit was given for additional months of such a leave.
- Military leave of absence
- In general, your service credit continued to accumulate throughout any military leave of absence, provided you returned to work within 90 days of your date of discharge.
- Full separation
- Service credit that you had earned before a full separation did not carry over to subsequent periods of employment.

May 1, 1981 and After

- Layoff
- Your service continues to accumulate during the period of a layoff, provided your return to work occurs within 12 months. If you have not returned from layoff by the end of 12 months, you are fully separated from the payroll and your service credit ends as of the effective date of layoff.
- Approved personal leave of absence
- Your service continues to accumulate during the period of approved leave of absence provided your return to work occurs within 12 months. If you do not return from the leave on the specified date, you are fully separated from the payroll and your service credit ends as of the effective date of the leave. Should a leave period be continued beyond a 12-month period, no further service credit would be accumulated.
- Military leave of absence
- In general, your service credit continues to build throughout a military leave of absence, provided you return to work within 90 days of discharge.
- Full separation
- Your service credit ends as of the date of full separation, sometimes called the "severance date" unless such full separation was immediately preceded by a period of layoff or leave of absence. In the latter instances, service credit would end as of the effective date of layoff or leave. If you are subsequently reemployed within the one-year period following such severance date, credit is restored for the prior period of service, but no credit is given for the period of separation. If you are re-employed more

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than one year after your severance date, you may receive credit for your former service upon completion of one additional year of service, but only if your former service equals or exceeds the period of separation. No credit is granted for the period of separation.

- Your service credit may be affected in one other special situation. If you are absent because of illness or injury, your service continues to build as long as you are receiving benefits from a company plan with one exception. Service for purposes of determining the amount of a termination allowance does not accumulate during any time you are receiving benefits from the Long Term Disability Plan.

If you have a question concerning your service with the company as it relates to your benefits, contact the Human Resources Service Center at 1-866-YOURHR3 (968-7473) on business days and press zero to speak with a representative. In the event there is any disagreement between this brief description of company service and the document titled "Regulations for Determining Service," the document will govern. A final decision as to any dispute will be made by the Retirement and Benefit Plans Committee.

Privacy of Your Health Information

Effective April 14, 2003, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that the Peoples Energy Corporation Comprehensive Group Insurance Plan ("the Plan") which includes the following programs: Medical and Dental Plan, Medicare Supplement Plan and Health and Dependent Care Spending Accounts Plan, protect the confidentiality of your private health information.

A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was previously distributed to you and is available on the Intranet or from Human Resources.

The Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

To receive more information about our privacy practices or your rights, please contact the Plan at the address or phone listed in the *Program Contacts* section at the front of this handbook.

EXHIBIT 5

EXHIBIT 6

2007 health care benefits comparison

Please insert this chart into your Benefits Handbook.

BCBS PPO Medical Plan

All **In-Network** medical expenses except for prescription drugs (Caremark), are subject to the Schedule of Maximum Allowances (SMA). The SMA is the amount determined by BlueCross BlueShield, which Participating Professional Providers have agreed to accept as payment in full for a particular covered service. All benefit payments for covered services rendered by Participating Professional Providers will be based on the SMA.

All **Out-of-Network** medical expenses are based on reasonable and customary standards (R&C). An R&C charge is one that does not exceed the general level of charges made by doctors or other providers with similar backgrounds in the same locality, as defined by the Claims Administrator. All benefit payments for covered services rendered by Non-Participating Professional Providers will be based on R&C standards.

All medical expenses, except those for prescription drugs, are subject to annual deductibles as detailed below. Reimbursement is at 100%, once the applicable annual out-of-pocket maximum plus deductible for covered items are met.

Hospital inpatient services are subject to the Medical Services Advisory Review Program criteria.

The maximum lifetime benefit available is $1,000,000 per covered person, which includes benefits paid for psychiatric and substance abuse services and prescription drugs. Psychiatric and substance abuse benefits are subject to a 60-day inpatient lifetime maximum per covered person.

Aetna HealthFund Medical Plan

All **In-Network** medical expenses are subject to the Schedule of Maximum Allowances (SMA). The SMA is the amount determined by Aetna, which Participating Professional Providers have agreed to accept as payment in full for a particular covered service. All benefit payments for covered services rendered by Participating Professional Providers will be based on the SMA.

All **Out-of-Network** medical expenses are based on reasonable and customary standards (R&C). An R&C charge is one that does not exceed the general level of charges made by doctors or other providers with similar backgrounds in the same locality, as defined by the Claims Administrator. All benefit payments for covered services rendered by Non-Participating Professional Providers will be based on R&C standards.

Pre-certification required for all in-patient services. Penalty applies for each out-of-network occurrence. All medical expenses, except those for prescription drugs, are subject to annual deductibles as detailed below. Reimbursement is at 100%, once the applicable annual out-of-pocket maximum plus deductible for covered items are met.

The maximum lifetime benefit is unlimited, except where indicated.

BENEFIT PROVISIONS	In-Network	Out-of-Network	In-Network	Out-of-Network
	Physician and/or Hospital must be in the BLUE CROSS BLUE SHIELD PPO Network www.bcbsil.com Deductible: Officers: $400 per person/$800 per family Exempt Employees/Retirees: $250 per person/$500 per family Non-Exempt Employees: $200 per person/$400 per family Out-of-Pocket Max: $1,500 per person or $2,500 per family	Deductible: Officers: $500 per person/$1,000 per family Exempt Employees/Retirees: $500 per person/$1,000 per family Non-Exempt Employees: $400 per person/$800 per family Out-of-Pocket Max: $3,000 per person or $4,500 per family	**Physician and/or Hospital must be in the Aetna Network** www.aetna.com HealthFund Amount: $500 Employee; $750 Employee+1; $1,000 Family (one fund is used for both in- and out-of-network care) Deductible: $1,000 Employee, $1,500 Employee+1, $2,000 Family Out-of-Pocket Max: $1,500 Employee, $2,250 Employee+1, $3,000 Family	Deductible: $1,500 Employee, $2,250 Employee + 1, $3,000 Family Out-of-Pocket Maximum: $3,000 Employee, $4,500 Employee + 1, $6,000 Family
EMERGENCY SERVICES 24-hour physician care (emergency care) Non-emergency use of the Emergency Room	80% of SMA	80% of R&C	90% of SMA 50% of SMA	90% of R&C 50% of R&C
HOSPITAL INPATIENT SERVICES Room and board, general nursing	80% of SMA – unlimited days	60% of R&C – unlimited days	90% of SMA	70% of R&C
Hospital services: use of operating room; radioisotopes; oxygen; laboratory services; X-rays; prescription drugs; anesthesia	80% of SMA	60% of R&C	90% of SMA	70% of R&C
Surgery	80% of SMA	60% of R&C	90% of SMA	70% of R&C
Visits by physician/consulting specialists	80% of SMA	60% of R&C	90% of SMA	70% of R&C
Obstetrical services (delivery)	80% of SMA	60% of R&C	90% of SMA	70% of R&C
Physical, occupational and speech therapy	80% of SMA	60% of R&C	90% of SMA	70% of R&C
OUTPATIENT SERVICES **Wellness Benefits** ➢ Office visits for a routine physical ➢ Immunizations (travel-related excluded) ➢ Routine labs, X-rays and blood tests ➢ Routine gynecological examinations ➢ Routine Pap smears ➢ Well child care (children under age 6)	100% of SMA up to $250 annual limit per person, per year with no deductible, then subject to the deductible and 80% of SMA thereafter	60% of R&C after applicable deductible	100% up to the preventative care maximum, then subject to the deductible and 90% thereafter Well child care (children up to age 18, Age/Frequency Schedule may apply)	100% not subject to deductible up to preventative care maximum, 70% of SMA after the applicable deductible thereafter. Well child care (children up to age 18, Age/Frequency Schedule may apply)
➢ Routine mammogram (Baseline-ages 35-40) (age 40 and above) ➢ Routine PSA screening (age 40 and over) ➢ Routine Colonoscopy screening	100% of SMA above and beyond $250 annual per person limit, no deductible.	60% of R&C after applicable deductible	100% of SMA not subject to deductible, fund or $250 preventive care maximum (see above)	70% of SMA after the applicable deductible.
CorSolutions 24/7 Nurse Connections Line-1-866-676-0740 ➢ Access to online health risk assessment ➢ Use of ecorsolutions.com web site ➢ Educational materials	100% Company Paid	100% Company Paid	100% Company Paid	100% Company Paid
Visits to physicians office	80% of SMA for services related to bodily injury, illness or pregnancy	60% of R&C for services related to bodily injury, illness or pregnancy	90% of SMA after applicable deductible	70% of R&C after applicable deductible
Visits to consulting specialists	80% for 2nd opinion surgery and other charges subject to SMA	60% for 2nd opinion surgery and other charges subject to R&C	90% of SMA after applicable deductible	70% of R&C after applicable deductible
Diagnostic services	80% of SMA	60% of R&C	90% of SMA	70% of R&C
Injections	80% of SMA only if medical condition requires	60% of R&C only if medical condition requires	90% of SMA only if medical condition requires	70% of R&C only if medical condition requires
Outpatient surgery	80% of SMA	60% of R&C	90% of SMA	70% of R&C
Maternity care (including pre- and post-natal care)	80% of SMA	60% of R&C	90% of SMA	70% of R&C
Vision care	80% up to $200 per person, per year for routine eye exams, glasses and contact lenses, with no deductible	80% up to $200 per person, per year for routine eye exams, glasses and contact lenses, with no deductible	90% for eye exam after deductible. $200 maximum per person, per year for glasses and contact lenses, not subject to fund, deductible.	70% for eye exam after deductible. $200 maximum per person, per year for glasses and contact lenses, not subject to fund, deductible
Pre-admission and post-hospital testing	80% of SMA	60% of R&C	90% of SMA	70% of R&C

NON-UNION 11/06

EXHIBIT 6

2007 health care benefits comparison

Please insert this chart into your Benefits Handbook.

BCBS PPO Medical Plan

All **In-Network** medical expenses except for prescription drugs (Caremark), are subject to the Schedule of Maximum Allowances (SMA). The SMA is the amount determined by BlueCross BlueShield, which Participating Professional Providers have agreed to accept as payment in full for a particular covered service. All benefit payments for covered services rendered by Participating Professional Providers will be based on the SMA.

All **Out-of-Network** medical expenses are based on reasonable and customary standards (R&C). An R&C charge is one that does not exceed the general level of charges made by doctors or other providers with similar backgrounds in the same locality, as defined by the Claims Administrator. All benefit payments for covered services rendered by Non-Participating Professional Providers will be based on R&C standards.

All medical expenses, except those for prescription drugs, are subject to annual deductibles as detailed below. Reimbursement is at 100%, once the applicable annual out-of-pocket maximum plus deductible for covered items are met.

Hospital inpatient services are subject to the Medical Services Advisory Review Program criteria.

The maximum lifetime benefit available is $1,000,000 per covered person, which includes benefits paid for psychiatric and substance abuse services and prescription drugs. Psychiatric and substance abuse benefits are subject to a 60-day inpatient lifetime maximum per covered person.

Aetna HealthFund Medical Plan

All **In-Network** medical expenses are subject to the Schedule of Maximum Allowances (SMA). The SMA is the amount determined by Aetna, which Participating Professional Providers have agreed to accept as payment in full for a particular covered service. All benefit payments for covered services rendered by Participating Professional Providers will be based on the SMA.

All **Out-of-Network** medical expenses are based on reasonable and customary standards (R&C). An R&C charge is one that does not exceed the general level of charges made by doctors or other providers with similar backgrounds in the same locality, as defined by the Claims Administrator. All benefit payments for covered services rendered by Non-Participating Professional Providers will be based on R&C standards.

Pre-certification required for all in-patient services. Penalty applies for each out-of-network occurrence. All medical expenses, except those for prescription drugs, are subject to annual deductibles as detailed below. Reimbursement is at 100%, once the applicable annual out-of-pocket maximum plus deductible for covered items are met.

The maximum lifetime benefit is unlimited, except where indicated.

BENEFIT PROVISIONS	In-Network	Out-of-Network	In-Network	Out-of-Network
	Physician and/or Hospital must be in the BLUE CROSS BLUE SHIELD PPO Network www.bcbsil.com Deductible: Officers: $400 per person/$800 per family Exempt Employees/Retirees: $250 per person/$500 per family Non-Exempt Employees: $200 per person/$400 per family Out-of-Pocket Max: $1,500 per person or $2,500 per family	Deductible: Officers: $500 per person/$1,000 per family Exempt Employees/Retirees: $500 per person/$1,000 per family Non-Exempt Employees: $400 per person/$800 per family Out-of-Pocket Max: $3,000 per person or $4,500 per family	**Physician and/or Hospital must be in the Aetna Network** www.aetna.com HealthFund Amount: $500 Employee; $750 Employee+1; $1,000 Family (one fund is used for both in- and out-of-network care) Deductible: $1,000 Employee, $1,500 Employee+1, $2,000 Family Out-of-Pocket Max: $1,500 Employee, $2,250 Employee+1, $3,000 Family	Deductible: $1,500 Employee, $2,250 Employee + 1, $3,000 Family Out-of-Pocket Maximum: $3,000 Employee, $4,500 Employee + 1, $6,000 Family
OTHER SERVICES (Maximums are combined in- and out-of-network) Extended care facility	80% of SMA, for up to 60 days, subject to certain limitations	60% of R&C, for up to 60 days, subject to certain limitations	90% of SMA, for up to 60 days, subject to certain limitations	70% of R&C, for up to 60 days, subject to certain limitations
Ambulance (ground)	80% of SMA	80% of R&C	90% of SMA	90% of R&C
Blood or blood plasma	80% of SMA	80% of R&C	90% of SMA	70% of R&C
Home health care (nursing)	80% of SMA, subject to certain limitations	60% of R&C, subject to certain limitations	90% of SMA, subject to certain limitations	70% of R&C, subject to certain limitations
Private duty nursing (out of hospital)	80% of SMA, up to $1,000 per person, per month	80% of R&C, up to $1,000 per person, per month	90% of SMA, subject to certain limitations	70% of R&C, subject to certain limitations
Physical, occupational and speech therapy	80% of SMA, up to $1,000 per person, per year	80% of R&C, up to $1,000 per person, per year	90% of SMA, subject to certain limitations	70% of R&C, subject to certain limitations
Prosthetic appliances (non-dental)	80% of SMA, only if medical condition requires	80% of R&C, only if medical condition requires	90% of SMA, only if medical condition requires	70% of R&C, only if medical condition requires
TMJ (temporomandibular joint)	80% of SMA, up to $1,000 per person, per year	60% of R&C, up to $1,000 per person, per year	90% of SMA	70% of R&C
Chiropractic Services	80% of SMA, up to $1,000 per person, per year	60% of R&C, up to $1,000 per person, per year	90% of SMA, limited to 20 visits per person, per yer	70% of R&C, limited to 20 visits per person, per year
Allergy treatment/testing	80% of SMA, only if medical condition requires	60% of R&C, only if medical condition requires	90% of SMA, subject to certain limitations	70% of R&C, subject to certain limitations
Hospice inpatient care	80% of SMA, subject to certain limitations	60% of R&C, subject to certain limitations	90% of SMA, subject to certain limitations	70% of R&C, subject to certain limitations
Hospice home care services	80% of SMA, subject to lifetime maximum of $12,500	60% of R&C subject to lifetime maximum of $12,500	90% of SMA, subject to lifetime maximum of $12,500	70% of R&C subject to lifetime maximum of $12,500
PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES	Deductible: None Out-of-Pocket Maximum: $1,000 per person Day and visit maximums: Combined in- and out-of-network	Deductible: None Out-of-Pocket Maximum: Not Applicable Day and visit maximums: Combined in- and out-of-network	Deductible: Included in Plan Deductible Day and visit maximums: Combined in- and out-of-network	Deductible: Included in Plan Deductible Day and visit maximums: Combined in- and out-of-network
Room and board, general nursing (Psychiatric or substance abuse)	80% of SMA for up to 30 days per calendar year per covered person subject to a 60 day inpatient lifetime maximum per covered person	50% of usual and customary charges for up to 30 days per calendar year per covered person subject to a 60 day in-patient lifetime maximum per covered person	90% of SMA charges for up to 30 days per calendar year per covered person subject to a 60 day inpatient lifetime maximum per covered person	50% of usual and customary charges for up to 30 days per calendar year per covered person subject to a 60 day in-patient lifetime maximum per covered person
Consultations (outpatient)	100% of SMA subject to a $15 copay per visit for up to 30 visits per calendar year per covered person	50% of usual and customary charges for up to 30 visits per calendar year per covered person	90% of SMA charges for up to 30 visits per calendar year per covered person	50% of usual and customary charges for up to 30 visits per calendar year per covered person
PRESCRIPTION DRUGS	**Pharmacist must be in the CAREMARK Network** www.caremark.com Retail Program (30-day supply): First two fills (Greater of 20% or); Third and subsequent (Greater of 30% or) Mail Service Program (90-day supply) (Flat Fee ...) Generic $7.50 / $7.50 / $15 Formulary $20 / $20 / $30 Brand Name $35 / $35 / $45 Deductible: None Refill Limit: None Annual Out-of-Pocket Maximum: $1,000	Not Covered	**Pharmacist must be in the Aetna Network** www.Aetna.com 100% after combined MedicalRX plan deductible and co-pay Retail Program (30-day supply Co-Pay) Mail Service Program 100% after combined MedicalRX plan deductible and co-pay (31 - 90-day supply) Generic $7.50 / $15 Formulary $20 / $30 Brand Name $35 / $45	Not Covered

Non-Union 11/06

EXHIBIT 6

EXHIBIT 7

SUMMARY		Claim No.:	704795002290C
Total Billed:	**$7229.16**	Patient Name:	PATRICIA SINTICH
Total Benefits Approved:	**$2053.10**		
Amount You May Owe Provider:	**$513.26**		

Blue Cross and Blue Shield has negotiated discounts with this provider. The following shows how the BCBS discount (ADP) is used to help lower your out-of-pocket expenses.

SERVICE INFORMATION

	Service Date	Amount Billed	Not Covered	Covered
JUSTICE MED SURG CENTER LTD				
Drugs	02-09-07	266.72		266.72
Med/Surg Supplies	02-09-07	3212.44		3212.44
Operating Room	02-09-07	3000.00		3000.00
Recovery Room	02-09-07	750.00		750.00
Totals		**$7229.16**		**$7229.16**

COVERAGE INFORMATION

Totals	**$7229.16**	**$0.00**	**$7229.16**
Discount (ADP)			-$4662.80
Deductions			
Your Coinsurance Amount		513.26	
Total Deductions			**-$513.26**
Total Benefits Approved			**$2053.10**
Amount You May Owe Provider			**$513.26**

Total covered benefits approved for this claim: $2,053.10 to JUSTICE MED SURG CENTER LTD DBA FOREST MED SURG CENTER on 02-23-07.

235,408 002573

EXHIBIT 7

AEE

EXHIBIT 8

9000 W 81ST STREET
JUSTICE, IL 60458
(708)594-3500

07/16/2007 00002674

Phone 708-594-3500

PATRICIA SINTICH
9304 LOCKWOOD PLACE
TINLEY PARK, IL 60477

☐ PLEASE CHECK IF ABOVE ADDRESS IS INCORRECT AND INDICATE CHANGE ON REVERSE SIDE.

AMOUNT ENCLOSED

To insure proper credit to your account, detach this portion and return it with your payment.

DATE	PATIENT	DESCRIPTION		INSURANCE CHARGES	PATIENT CHARGES
12/31/2006	P. SINTICH	PREVIOUS BALANCE	$0.00	$0.00	$0.00
02/09/2007	P. SINTICH	43250 - UPPER GI, HOT BIOPSY POLYP	$7,229.16	$7,229.16	$0.00
03/02/2007	P. SINTICH	INSURANCE PAYMENT	($986.74)	($986.74)	$0.00
03/02/2007	P. SINTICH	T - YOUR DEDUCTABLE/CO-INSURAN	$0.00	($513.26)	$513.26
03/02/2007	P. SINTICH	W - CONTRACT ADJUSTMENT	($5,729.16)	($5,729.16)	$0.00

INSURANCE BALANCE	$0.00	TOTAL PATIENT BALANCE

Page 1

STATEMENT DATE	CURRENT	30 DAYS	60 DAYS	90 DAYS	PAY THIS AMOUNT
07/16/2007	$0.00	$0.00	$0.00	$513.26	$513.26
	PATIENT OWED AMOUNT				

EXHIBIT 8

EXHIBIT 9

JUSTICE MED-SURG CENTER
9050 W 81ST STREET
JUSTICE IL 60458
PHONE 708-594-3500
FAX 708-563-594-8370

October 5, 2007

Office of the Attorney General
Attn: Amy Tibbetts
100 West Randolph 12th Floor
Chicago, Il 60601

Health Care Bureau Case# **2007-H-15285**
Patient: **Tricia Sintich**

Dear Amy Tibbetts,

Please find the enclosed explanation of medical benefits from patient Patricia Sintich date of service February 2, 2007. The billed amount was $7229.16 the paid amount was $6715.90. The patient's co-insurance was $513.26. Also, please find the enclosed reconciliation report received from Blue Cross and Blue Shield on April 2007. This report is very difficult to read and I had blocked out the other patient names. The refund we sent to Blue Cross and Blue Shield for the case was $5829.16. This refund due is shown in the contractual allowance. The patient portion is still $513.26. The payment from Blue Cross from the case after reconciliation is $986.74.
If you have any more questions please do not hesitate to call.

Thank You,

Tammy Timm
Administrator
Justice Med-Surg Center

EXHIBIT 9

4443.09

LAST NAME	P I	ADMIT DATE	DISCH DATE	GROUP NO.	SUB. NO.	PROVIDER PATIENT NUMBER	REIMBURSEMENT TYPE	NET COVERED CHARGES	TOTAL OTHER PMTS APPLIED	CONTRACTED PAYMENT	CONTRACTUAL ALLOWANCE
[redacted]		07/01/23	07/01/23	451468	0404000034511351	25	PERDIEM	5,332.11	436.98	1,313.82	4,469.03
[redacted]		07/01/66	07/01/66	P46391	0404000041845297	13	PERDIEM	6,759.47	214.55	1,265.45	3,491.82
[redacted]		06/12/23	06/12/23	P14475	4040400904013137	9	PERDIEM	7,713.52	.00	1,408.09	6,113.52
[redacted]		06/12/21	06/12/21	P15111	4000404040156831	24	PERDIEM	3,216.73	347.43	1,152.57	3,114.16
[redacted]		06/12/25	06/12/25	P11409	4040400000553341	10	PCT OF CHGS	1,787.93	.00	1,072.73	715.37
[redacted]		07/01/05	07/01/05	010114	4040400043534132	3	PERDIEM	6,974.19	392.35	1,187.75	5,816.44
[redacted]		07/01/26	07/01/26	P07369	4040000643735437	7	PERDIEM	6,365.03	444.11	853.59	5,510.48
[redacted]		06/12/06	06/12/06	216401	4040040040151762	7	PERDIEM	6,376.73	757.54	1,343.16	5,634.31
[redacted]		07/01/22	07/01/22	P15416	4040040440335630	16	PERDIEM	2,193.76	271.05	1,328.95	1,064.41
[redacted]		07/01/21	07/01/21	477150	4000040443421117	21	PERDIEM	4,597.71	418.19	1,319.50	5,617.11
[redacted]		07/01/23	07/01/23	404110A	0000004476014815	6	PERDIEM	7,140.74	549.73	354.26	6,155.18
[redacted]		07/01/26	07/01/26	XOPPOX	0000011054174401	23	PERDIEM	7,238.45	.00	1,400.09	5,758.26
[redacted]		06/11/13	06/11/13	XOHOST	0304019711947401	7	PERDIEM	6,540.51	527.49	372.51	3,318.00
[redacted]		07/01/21	07/01/21	477060	0404000049413424	21	PERDIEM	4,857.23	1,500.80	.00	4,357.33
[redacted]		06/08/25	06/08/25	XOPPOX	0404002011593318	21	PERDIEM	3,393.33	.00	1,500.09	6,108.33
[redacted]		06/12/19	06/12/19	P50421	0004000017663491	12	PERDIEM	7,106.16	.00	1,500.09	6,318.24
[redacted]		07/01/30	07/01/30	P11133	0004000019501316	9	PERDIEM	7,451.57	186.57	1,113.43	5,137.34
[redacted]		07/01/30	07/01/30	P14455	4000404064040234	15	PERDIEM	6,537.63	536.27	943.78	5,547.35
[redacted]		07/02/01	07/02/01	P73115	4000400041383415	14	PERDIEM	11,406.34	1,137.71	367.29	11,114.85
[redacted]		07/01/19	07/01/19	P70568	4040100064779530	3	PERDIEM	7,415.43	358.26	1,341.76	5,734.72
[redacted]		07/01/26	07/01/26	045518	4040004343674718	23	PERDIEM	10,442.11	767.47	731.53	3,345.58
[redacted]		07/01/09	07/01/09	XOPPOX	4040400435164571	29	PERDIEM	9,581.63	474.57	415.63	8,359.46
[redacted]		07/01/19	07/01/19	XOPPOX	0040040494361130	8	PERDIEM	7,183.33	457.31	407.69	6,362.64
[redacted]		07/01/23	07/01/23	P18715	0004000434418847	20	PERDIEM	4,335.51	610.87	459.13	7,315.18
[redacted]		07/01/19	07/01/19	P06944	0000000435540056	13	PERDIEM	5,541.03	816.85	483.35	7,417.54
[redacted]		07/01/18	07/01/18	423000	0404000049815873	4	PERDIEM	5,946.37	1,474.79	373.21	3,415.16
[redacted]		06/11/24	06/11/24	P15787	0404000044737367	10	PERDIEM	9,376.47	.00	1,500.09	7,376.67
[redacted]		07/01/41	07/01/41	P15782	0404000047375476	10	PERDIEM	11,314.36	434.53	1,461.40	16,163.05
[redacted]		07/01/65	07/01/65	XOPPOX	0004000195456514	36	PERDIEM	7,451.64	.00	1,500.40	5,931.64
[redacted]		07/02/05	07/02/05	049601	4000400046411343	7	PERDIEM	6,769.18	214.00	1,351.17	5,541.72
[redacted]		06/10/23	06/10/23	P40116	4000400041049179	23	PERDIEM	3,445.74	318.39	1,113.78	7,183.84
[redacted]		07/01/25	07/01/26	047467	4000400041591897	12	PERDIEM	7,241.89	590.54	900.46	6,914.38
[redacted]		07/01/26	07/01/25	P44004	4040000000316004	7	PERDIEM	4,613.87	735.77	765.23	5,517.34
[redacted]		07/01/22	07/01/22	041061	4040000454311119	2	PERDIEM	6,561.56	32.27	1,417.33	5,517.13
[redacted]		07/01/23	07/01/23	P11923	4040000454609114	9	PERDIEM	6,596.13	413.42	1,895.45	5,408.21
[redacted]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	5,707.26
[redacted]STICH	2	07/02/09	07/02/09	487646	0000404441712210	17	PERDIEM	5,715.98	513.24	506.74	5,715.16
[redacted]		[illegible]	[illegible]	[illegible]	[illegible]	3	PERDIEM	[illegible]	[illegible]	1,354.07	5,515.54
[redacted]		07/01/23	07/01/23	XOPPOX	0000000045954011	28	PERDIEM	6,559.38	692.92	837.93	5,701.39
[redacted]		07/02/41	07/02/41	155957	0000000541468367	25	PERDIEM	7,051.50	439.17	548.83	6,054.47
[redacted]		06/10/23	06/10/23	741111	0404000359701551	33	PERDIEM	7,113.60	59.00	1,141.40	5,574.49
[redacted]		07/02/46	07/02/46	XOPPOX	0404811015814901	1	PERDIEM	7,165.53	54.09	1,450.60	5,655.93
[redacted]		07/01/22	07/01/22	P06363	0404000048732234	2	PERDIEM	7,404.33	535.31	964.69	6,833.64
TOTAL PAID FOR OUTPATIENT								315,061.41	17,849.08	47,723.67	267,337.74
*TOTAL DISC_FLAG Y								315,061.41	17,849.08	47,723.67	267,337.74
*TOTAL PROCMOEND 02/2007								315,061.41	17,849.08	47,723.67	267,337.74
*TOTAL REPYEAR DECEMBER 31, 2007								315,061.41	17,849.08	47,723.67	267,337.74
*TOTAL PROVNO 50437								315,061.41	17,849.08	47,723.67	267,337.74

EXHIBIT 9

EXHIBIT 10

SUMMARY		Claim No.:	703857159730X
Total Billed:	$3691.72	Patient Name:	PATRICIA SINTICH
Total Benefits Approved:	$1512.14		
Amount You May Owe Provider:	$378.03		

Blue Cross and Blue Shield has negotiated discounts with this provider. The following shows how the BCBS discount (ADP) is used to help lower your out-of-pocket expenses.

SERVICE INFORMATION

	Service Date	Amount Billed	Not Covered	Covered
NORTHWESTERN MEMORIAL HOSPITAL				
Mri Outpatient	01-30-07	3691.72		3691.72
Totals		$3691.72		$3691.72

COVERAGE INFORMATION

Totals	$3691.72	$0.00	$3691.72
Discount (ADP)			-$1801.55
Deductions			
Your 20% Coinsurance Amount		378.03	
Total Deductions			-$378.03
Total Benefits Approved			$1512.14
Amount You May Owe Provider			$378.03

Total covered benefits approved for this claim: $1,512.14 to NORTHWESTERN MEMORIAL HOSPITAL on 02-23-07.

235,402 002573

EXHIBIT 10

EXHIBIT 11

June 7, 2007

Mrs. Patricia Sintich
9304 Lochwood Lane
Tinley Park, IL 60487-4797

Dear Mrs. Sintich,

This is in response to your recent inquiries regarding the payment practices of BlueCross BlueShield of Illinois (BCBS).

First, I agree with your statement that BCBS payment practices are complex. However, the methodology used by BCBS is legal, documented and filed with the Department of Insurance. The Peoples Energy Medical and Dental Plan (the Plan) has a contract with BCBS and has agreed to this same methodology. In addition, the Plan is audited regularly by external auditors who have not identified any irregularities or discrepancies.

You questioned the amount of your $513.26 co-insurance for a procedure done on February 9th at the Justice Medical Surgical Center. As stated in the Peoples Energy Benefits Handbook, all in-network medical expenses are subject to the Schedule of Maximum Allowances (SMA). The SMA is the amount determined by BCBS which Participating Professional Providers have agreed to accept as payment in full for a particular covered service. All benefit payments for covered services rendered by Participating Professional Providers will be based on the SMA.

The SMA for this procedure was $2,566.36 making your twenty percent co-insurance $513.26. The contract between BCBS and its in-network facilities states that the full allowable amount is paid upfront, (in this instance $6,715.90). Then the Participating Professional Providers will reimburse BCBS through a reconciliation process for the discount amount. However, the Plan is only invoiced and pays for eighty percent of the SMA or ($2,053.10).

The same explanation holds true for the benefits approved and paid to Northwestern Memorial Hospital for your March services.

You also expressed concern about the reduced amount BCBS paid to the Justice Medical Surgical Center and Northwestern Memorial Hospital. BCBS has a separate financial arrangement with Participating Professional Providers that allows BCBS to pay less, often substantially less and requires the hospital or facility to accept less than the amount of money BCBS would be required to pay if it did not have a contract. BCBS receives and keeps for its own account the difference between the bill and whatever BCBS ultimately pays under its contracts with Participating Professional Providers and neither you nor the Plan is entitled to any part of these savings. Again, the terms of

these contracts are legal, documented and filed with the Illinois Department of Insurance.

Please contact me if you have additional questions regarding the above.

Sincerely,

Joyce K. Daniel
Manager, Benefits Administration

EXHIBIT 11

EXHIBIT 12

July 19, 2007

Ms. Joyce Daniel
Manager, Benefits Administration
Integrys

Dear Ms. Daniel:

I am writing in response to your letter dated June 7, in which you attempt to address my concerns with the self-funded insurance plan administered by Blue Cross Blue Shield of Illinois.

According to the Benefits Summary provided by Peoples Energy, employees and dependents who access care from BCBS PPO network providers receive benefits for covered medical expenses at 80% of the Schedule Maximum Allowance (SMA), as determined by BCBS, after satisfaction of the plan deductible.

The Benefit Summary defines the SMA as:

"The amount determined by BlueCross BlueShield which Participating Professional Providers have agreed to accept as payment in full for a particular covered service. All benefit payments for covered services rendered by Participating Professional Providers will be based on the SMA."

When I initially contacted you, I advised that Justice Medical Surgical Center billed BCBS $7229.16 for services I received in February. Justice Medical Surgical Center subsequently wrote off $5729.16 to "Contract Adjustment", leaving a balance of $1500. Justice Medical Surgical Center confirmed that under their contract with BCBS, they agree to accept $1500 per case as payment in full.

Therefore, in accordance with my Peoples' Energy benefit plan, BCBS should have paid 80% of the SMA, or $1200, and my 20% coinsurance should be $300.

When I received the Explanation of Benefits from BCBS, it showed a "discount" of only $4662.80, making the SMA on which BCBS calculated my coinsurance, $2566.36. The EOB also reflects a BCBS payment of $2053.10 to Justice Medical Surgical Center.

According to the statement I received from Justice Medical Surgical Center, BCBS actually paid only $986.74. That amount, combined with my "coinsurance" of $513.26, equals the actual contract rate of $1500.

I reported to you a similar situation in which Northwestern Memorial Hospital billed BCBS $3691.72 for radiology services rendered in January. The BCBS EOB reflects a discount of

$1801.55, making the SMA $1890.17, and my coinsurance $378.03. The EOB reflects a payment of $1512.14 to Northwestern Memorial Hospital.

When I spoke with NMH representatives, however, they indicated that the payment they actually received from BCBS was less than the amount shown on the EOB. They are reluctant to tell me their actual BCBS contract rate, but they did verify that the amounts on my EOB do not reflect the actual payment received, nor the true discount amount.

According to your June 7 letter, "BCBS receives and keeps for its own account the difference between the bill and whatever BCBS ultimately pays under its contracts with Participating Professional Providers and neither you, nor the Plan is entitled to any part of these savings."

Ms. Daniels, is the employee benefit plan offered to Peoples Energy employees not a self-funded plan, administered by BCBS? As such, when claims are paid, are they not paid with Peoples' Energy funds?

If the SMA is defined as the amount a provider agrees to accept as payment in full, and if the employee benefit plan states that Peoples' Energy will pay 80% of the SMA for covered services, doesn't Peoples' Energy, in fact, benefit from a system in which BCBS inflates the SMA on the patient's EOB, resulting in the patient paying more than 20% of the ***actual*** SMA?

Please help me understand:

Why the allowed amount on the EOB for Justice Medical Surgical Center reflects $2566.36, when Justice Medical Surgical Center wrote off all but $1500 to "Contract Adjustment"

Why, if the SMA is ***really*** $2566.36, did BCBS pay, on behalf of Peoples Energy, only $986.74 instead of $2053.08?

Why, when the actual paid amount of $986.74 is added to the coinsurance shown on the EOB, does it total $1500, the amount Justice Medical Surgical Center asserts is its actual BCBS contract rate?

Why does Peoples' Energy advise its employees and dependents that they are entitled to receive 80% of the SMA, when we are really receiving only 65%?

In your June 7 letter you state, "the methodology used by BCBS is legal, documented and filed with the Department of Insurance", and, Ms. Daniel, that may, indeed, be the case. I must question, however, the legality and ethics of the blatant misinformation provided to Peoples' Energy employees and their families.

I understand you are retiring at the end of this month. I would appreciate you forwarding this correspondence to your successor; I look forward to his or her timely response.

Sincerely,

Tricia Sintich

cc: Justice Medical Surgical Center
Illinois Attorney General, Healthcare Bureau

EXHIBIT 12

EXHIBIT 13

integrys™

Integrys Business Support, LLC
700 North Adams Street
P.O. Box 19001
Green Bay, WI 54307-9001
www.integrysgroup.com

November 19, 2007

Mrs. Patricia A. Sintich
9304 Lochwood Lane
Tinley Park, IL 60487

Dear Mrs. Sintich,

This letter is in response to your letter dated July 19, 2007 to Mrs. Joyce Daniel. It is my understanding that you initially contacted Mrs. Daniel on April 24, 2007, questioning the payment issued by Blue Cross Blue Shield (BCBS) for charges you incurred in February of 2007 in the amount of $7,229.16 from Justice Medical Surgical Center.

In a letter dated June 7, 2007 from Mrs. Daniel to you, Mrs. Daniel made reference to the Schedule of Maximum Allowances as stated in your Benefits Summary. Please be advised that the Schedule of Maximum Allowances (SMA) as stated in your Benefits Summary applies to **Professional** Providers. In fact, as you quote the Benefit Summary in your letter it reads:

The amount determined by Blue Cross Blue Shield which Participating Professional Providers have agreed to accept as payment in full for a particular covered service.

It should be noted that Justice Medical Surgical Center is a licensed Ambulatory Surgery Center and has a facility contract with BCBS. As a surgery center, they bill for operating room, supplies and other items that are included in a case rate negotiated by BCBS for the service. Licensed surgery centers, like hospitals, are not reimbursed by the SMA but are reimbursed at the individually negotiated rate stated in their contract with BCBS.

BCBS has separate, individual financial agreements with facilities. Customers and members are entitled to the Average Discount Percentage (ADP) of these contracts; the average determined by the grouping by facility type and geography. Peoples Gas and Light and the Illinois Department of Insurance are aware of the complexity of the payment methodology. This methodology is legal, documented and filed with the Department of Insurance. In addition, the Peoples Gas and Light Medical and Dental Plans and the BCBS payment methodology is audited regularly by external auditors.

I have enclosed specific BCBSIL contract language that explains the separate financial arrangements with providers, with examples for your review.

EXHIBIT 13

It is our determination that the claims have been paid in accordance with plan provisions and no additional benefits are due.

If you have further questions regarding the processing of your claims, please contact the Full Service Unit at the Customer Service number listed on the back of your identification card.

Sincerely,

Jennifer Niemi
Benefits Manager

C: Jan Cohen
Paul Motondo
Josh Salvia

EXHIBIT 13

EXHIBIT 14

GENERAL PROVISIONS

1. BLUE CROSS AND BLUE SHIELD'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

Blue Cross and Blue Shield hereby informs you that it has contracts with certain Providers ("Plan Providers") in its service area to provide and pay for healthdental care services to all persons entitled to healthdental care benefits under healthdental policies and contracts to which Blue Cross and Blue Shield is a party, including all persons covered under this Certificate. Under certain circumstances described in its contracts with Plan Providers, Blue Cross and Blue Shield may:

- receive substantial payments from Plan Providers with respect to services rendered to you for which Blue Cross and Blue Shield was obligated to pay the Plan Provider, or
- pay Plan Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Plan Providers other substantial allowances under Blue Cross and Blue Shield's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by Blue Cross and Blue Shield under this Certificate and the calculation of all required deductible and Coinsurance amounts payable by you under this Certificate shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Group has been advised that Blue Cross and Blue Shield may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Group nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how Blue Cross and Blue Shield's separate financial arrangements with Providers work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your Certificate.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the deductible and Coinsurance amounts, Blue Cross and Blue Shield will satisfy its portion of the Hospital bill. In most cases, Blue Cross and Blue Shield has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money Blue Cross and Blue Shield would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then Blue Cross and Blue Shield has to satisfy the rest of the Hospital bill, or $860. Assuming Blue Cross and Blue Shield has a contract with the Hospital, Blue Cross and Blue Shield will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. Blue Cross and Blue Shield receives, and keeps for its own account, the difference between the $860 bill and whatever Blue Cross and Blue Shield ultimately pays under its contracts with Plan Providers, and neither you nor your Group are entitled to any part of these savings.

EXHIBIT 15

January 24, 2008

BlueCross BlueShield of Illinois
P.O. Box 1220
Chicago, IL 60690-1220

Integrys, Human Resources Department
700 North Adams Street
P.O. Box 19001
Green Bay, WI 54307-9001

Dear Sir/Madam:

My husband and I have medical coverage through the preferred provider organization (PPO) option of the Peoples Energy Corporation Medical Plan (Plan), for which BlueCross Blue Shield of Illinois (BCBS) serves as the claims administrator. This letter is intended to be a formal claim for benefits, as explained below.

The Benefits Handbook provided by Peoples Energy states as follows:

> The plan generally pays a major portion of the medical expense for care of bodily injury and illness and for pregnancy. Hospital charges and doctors' fees for inpatient and for outpatient care are included. A Schedule of Maximum Allowances is set on these charges and fees by the Claims Administrator based on what the participating professional providers have agreed to accept as payment in full for a particular covered service. All in-network medical expenses, except those for mental health/substance abuse and prescription drugs, are subject to the Schedule of Maximum Allowances.

The Benefits Handbook states, "The Schedule of Maximum Allowances represents discounted amounts for services negotiated by BlueCross BlueShield with contracted providers." The Handbook further states, "Keep in mind that the amount charged in-network by a hospital or doctor will be determined based on the Schedule of Maximum Allowances."

The plan document I have received (effective January 1, 2002) provides that benefits for inpatient care at a recognized hospital, and outpatient care (including, among other things, in-network charges for outpatient surgery "at a doctor's office or clinic, Hospital or ambulatory surgical facility") are payable at 80% "of the Claims Administrator's Schedule of Maximum Allowances." The plan document specifically defines Schedule of Maximum Allowances to "mean those charges for medical services as negotiated by the Preferred Provider Organization for In-Network services."

The "2007 Benefits Open Enrollment Guide" provided to Plan participants also informed them that "Contracting Providers have agreed to accept the Schedule of Maximum Allowances as payment in full for covered services." In addition, the "2007 health care benefits comparison" chart provided to Plan participants states that the Plan pays "80% of the SMA" for most services,

including for surgery, outpatient surgery, hospital services (including use of operating room, radioisotopes, oxygen, laboratory services, X-rays, prescription drugs and anesthesia), and diagnostic services.

In February, I received medical services consisting of surgery and related services (operating room, recovery room, drugs, supplies) from Justice Medical Surgical Center (Justice), an in-network provider. Justice billed BCBS $7,229.16 for these services. Justice then wrote off $5,729.16 of this amount to "Contract Adjustment," leaving a balance of $1,500. Justice confirmed to me that under its contract with BCBS, it agrees to accept $1,500 per case as payment in full. Therefore, in accordance with the Plan, BCBS should have paid 80% of the amount that the Plan negotiated for the services, and that Justice agreed to accept as payment in full for the services, (i.e., the SMA), or $1,200, and my 20% co-insurance should have been $300.

Notwithstanding that Justice agreed to accept $1500 as payment in full for these services, the Explanation of Benefits (EOB) I received from BCBS showed a "discount" of only $4,662.80, leaving a balance of $2,566.36. The EOB reflects that the total benefits BCBS approved for this claim was $2,053.10 (80% of this balance), and that my co-insurance obligation for these services was $513.26 (20% of this balance). However, according to the statement received from Justice, BCBS actually paid benefits of only $986.74, the difference between the $1500 Justice agreed to accept as payment and the $513.26 co-insurance obligation. Thus, rather than paying 80% of the SMA for these services as the Plan requires (i.e., $1200), BCBS paid only about 66% of the SMA. I am therefore owed $213.26 in benefits for these services (plus interest).

The bill received from Justice for these services, as well as the EOB received from BCBS and the correspondence among BCBS, Justice and the Illinois Office of Attorney General related to the payment of benefits for these services, are attached to this letter.

A similar situation occurred in connection with radiological services I received from Northwestern Memorial Hospital (Northwestern) on January 30, 2007. The EOB received from BCBS reflects an amount billed of $3,691.72 and a discount of $1,801.55, leaving a balance of $1,890.17. The EOB further reflects that BCBS approved benefits for this claim in the amount of $1,512.14 (80% this balance), and that my co-insurance obligation for these services was $378.03 (20% of this balance). When I spoke to Northwestern representatives, however, they indicated that the payment Northwestern actually received was less than the amount shown on the EOB. They declined to tell me Northwestern's actual contract rate with BCBS, but they did verify that the amounts on the EOB do not reflect the actual payment received, nor the true discount amount. Thus, BCBS paid less than 80% of the SMA for these services, and I am owed further benefits for these services as well.

The EOB received from BCBS for these services is attached.

I am very concerned that BCBS has underpaid benefits not only on these two claims, but on many claims for medical services rendered to other persons in the People's Energy Plan, and persons covered by other plans administered or insured by BCBS. I am also concerned about,

and hence complain about, the apparent fact that excess funds I and others have been charged and required to pay are either being misappropriated or misused by BCBS or Peoples Energy, or are being used to defray or pay their obligations under the Plan.

I have already been in contact with BCBS and the Human Resources Department regarding these claims on an informal basis, without any success or satisfactory explanation. In the Human Resources Department's latest communication with me, dated November 19, 2007, Ms. Jennifer Niemi wrote that Justice "is a licensed Ambulatory Surgical Center and has a facility contract with BCBS," and also that "Licensed surgery centers, like hospitals, are not reimbursed by the SMA but are reimbursed at the individually negotiated rate stated in their contract with BCBS." This is flatly contradicted by the language of the plan document (and the Benefits Handbook) which unequivocally (i) states that benefits for in-network charges "for outpatient Surgery performed at a doctor's office or clinic, Hospital or ambulatory surgical facility" are payable at 80% of the SMA, and (ii) defines the SMA as "those charges for medical services as negotiated by the Preferred Provider Organization for In-Network services."

I now want to formally pursue the matter. This letter is intended to be a formal claim for benefits for all claims where BCBS handled the claim as in the examples given above, i.e., where BCBS calculated the Plan member's co-insurance obligation to be 20% (or some other percentage) of the "Benefits Approved" as reflected in the EOBs, but paid amounts to the providers that were less than 80% of the "Benefits Approved" (or initially paid 80% of the "Benefits Approved" but then received rebates or payments from the providers in connection with the claim). This letter is also intended to cause the cessation of and seek an appropriate remedy for any misappropriations or misuses of my, others' or Plan funds to defray provider costs, as described above.

It is not clear from the documents I have received if I have to go to BCBS or the HR Department. Therefore, I am writing and making this claim to both BCBS and the HR Department out of an abundance of caution. Whichever entity is supposed to address this in the first instance, please do so now, and please let me know who it is that is addressing this matter. In making this formal claim, I seek to have BCBS and the Plan recalculate the benefits owed for these claims and pay the difference (plus interest), correct any other issues that have resulted from the improper calculation of benefits, and ensure that all future claims are properly handled and paid in accordance with the language of plan documents.

In order to adequately pursue this matter, I request that you consider and that I be provided with the following information pertaining to this claim, and ask that I be allowed to submit additional information in support of the claim after I have received the requested information:

1. A statement of the status of the claim, the time frames that you believe apply, the procedures that you believe apply or which you think I have to follow, and any other information pertinent to the procedures of the claim and any appeals.

2. The complete claims histories and files for myself, my husband, and my two minor children, John and Emma, including, but not limited to, the amounts and history of our

co-insurance obligations as compared to the amounts paid to providers by BCBS on behalf of the Plan, including all EOBs and payment histories for such claims.

3. A copy of any documents, records or other information that were relied upon in making the benefit determinations.

4. A copy of any documents, records or other information that were submitted to, considered by or generated in the course of making the benefit determination, without regard to whether such documents, records or other information were relied upon in making the benefit determination.

5. A copy of any documents, records or other information that demonstrate compliance with administrative processes and safeguards required in making the benefit determination.

6. A copy of any documents, records or other information that constitute a statement of policy or guidance with respect to the Plan concerning the denied benefit, without regard to whether such were relied upon in making the benefit determination.

7. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a complete copy or statement of the specific rule, protocol or other similar criterion.

In addition, I ask that the entity handling this claim on behalf of the Plan consider, and provide to me complete copies of, the following documents and information pertaining to this claim:

8. All documents governing the Plan, including, but not limited to the legal plan document and all exhibits, riders, appendices, supplements, amendments or similar documents; the applicable summary plan descriptions; and any applications and agreements between BCBS and Peoples Energy.

9. All plan documents for the Plan that have been in effect during my participation in the Plan, including, but not limited to, all exhibits, riders, appendices, supplements, amendments or similar documents.

10. All summary plan descriptions that relate to, or have been in effect or existence during my participation in the Plan.

11. The latest annual report for the Plan.

12. All notices to plan participants and/or beneficiaries of amendment or alteration to plan documents, including any notice or summary of material modification to any of the documents governing the Plan.

13. The document, one part of which is attached to the letter to me from Jennefer Niemi dated November 19, 2007, which Ms. Niemi states is "the specific BCBSIL contract language that explains the separate financial arrangements with providers."

14. The payment methodology for all claims concerning in-network charges which, pursuant to the plan documents, are to be paid as a percentage of the SMA.

15. The payment methodology for all claims concerning charges of providers with which BCSB has entered into facility contracts.

16. Any plan interpretations of or relating to the plan provisions related to this matter, and a statement as to whether anyone else has ever challenged BCBS's payment methodologies, and if so, the documents relating to and the outcome of all such challenges.

17. The claims files for all claims where BCBS utilized the payment methodologies referenced in items 14 and 15 above.

18. All facility contracts that BCBS has entered into with providers from whom I have received services for which BCBS has paid benefits pursuant to the Plan.

19. The rate tables, fee schedules, or similar documents that constitute the "Schedule of Maximum Allowances" BCBS utilizes in administering the Plan.

20. The rate tables, fee schedules, or similar documents that set forth or otherwise identify the "Average Discount Percentages" BCBS utilizes in administering the Plan.

21. All filings, correspondence or other communications with the Illinois Department of Insurance that forms the basis of the assertions by Peoples Energy that BCBS's payment "methodology is legal, documented and filed with the Department of Insurance."

22. All audits of BCBS's payment methodologies by external auditors, as referenced in the correspondence I have received from Peoples Energy.

23. Any other document, agreement or guideline concerning BCBS's payment methodologies for claims concerning in-network charges which, pursuant to the plan documents, are to be paid as a percentage of the SMA, or claims concerning charges of providers with which BCSB has entered into facility contracts.

Thank you for your prompt attention to this matter.

Sincerely,

Tricia Sintich

EXHIBIT 16

From: Niemi, Jennifer A [mailto:JANiemi@integrysgroup.com]
Sent: Monday, April 14, 2008 04:02 PM Central Standard Time
To: tsintich@cinn.org
Cc: Cohen, Jan
Subject: Your letter of 1/24/08

Tricia,

Just wanted to drop you a quick note to let you know that we are working on our response to your letter of January 24, 2008.

We have been meeting with Blue Cross Blue Shield of Illinois and the respective legal counsel for both Integrys and BCBSIL to gather the data and our response. Our goal is to have our response to you by the end of the month.

Thanks

Jennifer Niemi
Benefits Manager
Integrys Energy Group
920 433-1071
janiemi@integrysgroup.com

EXHIBIT 16

EXHIBIT 17

From: Niemi, Jennifer A [mailto:JANiemi@integrysgroup.com]
Sent: Tuesday, May 20, 2008 3:45 PM
To: Sintich, Tricia
Cc: Cohen, Jan
Subject: Update

Tricia,

As I indicated in my e-mail on 4/14/08, we've been working on our response to your letter of 1/24/08 with Blue Cross Blue Shield of Illinois and the respective legal counsel for both BCBSIL and Integrys. Unfortunately, our data gathering is taking longer than anticipated. We continue to work on your request and will have it to you as soon as possible.

Jennifer Niemi, SPHR
Benefits Manager
Integrys Business Support, LLC
PO Box 19001
700 N. Adams
Green Bay, WI 54307
920 433-1071
920 433-1744 - fax
JANiemi@integrysgroup.com

Providing support for Integrys Energy Group, Integrys Energy Services, Michigan Gas Utilities, Minnesota Energy Resources, North Shore Gas, Peoples Gas, Upper Peninsula Power and Wisconsin Public Service

www.integrysgroup.com

EXHIBIT 17